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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TTVI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00930

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245313**
2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - MEADOW LANE**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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 **04/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **62** (L18)

13.Total Certified Beds **62** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	19		
(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): Post Certification Revisit (PCR) completed April 5, 2015, which included an investigation of complaint number H5313021, verified correction, effective March 25, 2015. Refer to the CMS 2567b.

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 04/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/30/2015 (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
05/01/1986
(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 05/06/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/25/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245313

April 30, 2015

Ms. Brooke Dillon, Administrator
Golden LivingCenter - Meadow Lane
2209 Utah Avenue
Benson, Minnesota 56215

Dear Ms. Dillon:

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 25, 2015 the above facility is certified for:

43	Skilled Nursing Facility/Nursing Facility Beds
19	Nursing Facility II Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 8, 2015

Ms. Brooke Dillon, Administrator
Golden LivingCenter - Meadow Lane
2209 Utah Avenue
Benson, MN 56215

RE: Project Number S5313025, H5313021

Dear Ms. Dillon:

On February 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on February 13, 2015 that included an investigation of complaint number H5313021. 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 April 5, 2015, 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 February 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2015, effective March 25, 2015 and therefore remedies outlined in our letter to you dated February 26, 2015, will not be imposed.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure 5313r15

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
245313	A. Building B. Wing	4/5/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

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 **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/25/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/25/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **03/25/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/25/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/25/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/25/2015**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **03/25/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	04/08/2015	28035	04/05/2015
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
2/13/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TTVI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00930

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245313**
2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - MEADOW LANE**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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 **02/13/2015** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **62** (L18)
13.Total Certified Beds **62** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	19		
(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):

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 03/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5313

On February 13, 2015 a standard survey was completed at this facility. Deficiencies were found with the most serioud deficiency cited at a scope and severity level of F. The facility has been given an opportunity to correct before remedies would be imposed.

In addition at the time of the standard survey an investigation was conducted of complaint number H5313021. The complaint was substantiated at F353. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0808

February 26, 2015

Ms. Brooke Dillon, Administrator
Golden LivingCenter - Meadow Lane
2209 Utah Avenue
Benson, Minnesota 56215

RE: Project Number S5313025 and H5313021

Dear Ms. Dillon:

On February 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 13, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5313021.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 13, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5313021 that was found to be substantiated at F353.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 25, 2015, 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 25, 2015 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 May 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 13, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter / eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5313s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____ RECEIVED MAR 13 2015	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

(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 electronic POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5313021 was completed. The complaint was substantiated. Deficiency issued at F353.	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 the applicable state and federal regulatory requirements.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete employee reference checks for 3 of 5 newly hired employees (NE-A, NE-B, NE-C) reviewed for abuse prohibition.	F 226	**F226** 1. Immediately pulled files of new hires and identified employees that did not have reference checks. 2. Re-trained hiring managers immediately on the understanding and importance of attempting to check references prior to hire. 3. BOM will photocopy listed references and date mailed to previous employers. 4. Random audits will be done by BOM/designee to ensure references have been mailed. Results reviewed at QAPI.	3-25-15 Approved w Addendum 3/18/15 30

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

Brooke Dillon | Executive Director | 3-10-2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

(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 226	Continued From page 1 Findings include: Review of the facility's policy and procedure titled Vulnerable Adult Maltreatment Plan, revised March 2012, indicated all applicants for employment in the facility shall, at a minimum, have the following screening checks conducted: 1. Reference checks with the current and/or past employer 2. Appropriate licensing board or registry check 3. Drug testing per facility policy 4. Fingerprint as required by state law 5. Criminal background check pursuant to facility policy or state law Review of the facility's work reference request forms revealed the following: -NE-A's work reference request form only had the employee's name printed on the form and did not direct the facility where to obtain the work reference from. NE-A's signature to authorize any release of information was also missing. -NE-B's work reference request form had the employees name, signature for release of information and location to send reference check. -NE-C's work reference request form had the employees name, signature for release of information and location to send reference check. During interview on 2/12/15, at 2:03 p.m. the administrator stated the usual facility practice was to mail the reference requests out and wait for an answer, then would call if no response. The administrator had visited with the director of nursing (DON) and reported the DON was not aware of the policy expectation. The administrator further confirmed the	F 226		

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F 226	Continued From page 2 aforementioned employee records lacked an attempt to check references as required.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide dignified care related to timely toileting assistance for 1 of 1 resident (R7) reviewed for dignity. Findings include: R7's quarterly Minimum Data Set (MDS) dated 12/5/14, indicated R7 was cognitively intact and had the following diagnoses: body myositis (a neuromuscular disorder), depression, osteoarthrosis, glaucoma and ulcerative colitis (inflamed colon). The MDS indicated R7 required extensive assistance with transfers, toileting and dressing. Further, the MDS identified R7 was always continent of bladder and bowel. R7's care plan revised on 6/17/14, identified R7 had a functioning deficit related to mobility impairments caused by body myositis and potential vision limitations. The care plan identified R7 required assistance of one staff and a mechanical standing lift to transfer to and from the toilet as requested by resident.	F 241	**F241** 1. Resident #7 is receiving care in a dignified manner. 2. All residents are receiving care in a dignified manner. 3. Random weekly call light audits and care observations done by DNS/Clinical Manager/Designee. 4. Review at QAPI if problem identified.	3-25-15

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F 241	Continued From page 3 During interview on 2/11/15, at 11:54 a.m. R7 stated the facility needed to have more staff on the floor to meet the needs of the residents. R7 stated approximately seven months ago he put the call light on at 10:00 a.m. to request assistance to use the bathroom and a nursing assistant came in right away, shut the call light off, told R7 she would let another staff member know he needed help and left the room. R7 stated he waited 10 minutes before he pushed the call light again and then waited another 45 minutes for staff response after that. R7 stated after waiting for another 55 minutes to use the toilet, the same nursing assistant came into his room that came in and shut off his light in the very beginning. R7 stated when the nursing assistant entered his room he told her he should not have to wait for a "God damn hour." R7 stated the nurse then entered his room and informed R7 he should not talk to the nursing assistant like that. R7 stated he informed the nurse that he should not have to wait for a whole hour to go the bathroom because staff take their break. R7 stated he told the nurse he had a bowel movement in bed while waiting for staff to help him. R7 stated it aggravated him that he had an accident in the bed and then had to lay in bed for an hour waiting for help. R7 stated there was no reason for it. During the same interview, R7 reported that two months ago his call light was on for 30 minutes while he waited for assistance to use the bathroom so he called the nursing home with his personal phone in order to get staff's attention. R7 stated a nurse answered the phone right away	F 241		

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F 241	Continued From page 4 and R7 stated he had identified himself and told the nurse he was going to "shit" his pants because no one would answer his call light and help him to the bathroom. R7 stated after the phone call staff finally made it to his room to assist him, but it was too late, he had already gone to the bathroom in his pants. R7 stated it made him feel bad. In addition, R7 stated on 2/7/15, at 4:45 a.m. he had put the call light on to use the bathroom. R7 stated the call light was not answered until 5:10 a.m. and at that point he had yelled out to the nurse that he had to go to the bathroom. R7 stated by the time staff got in to help him he had already gone in the bed. R7 stated staff are sorry they cannot get in to help him in time and stated the nurses helped the nursing assistants as much as they could, but they didn't like it. R7 stated some staff worked for 16 hours at a time, they call it "being frozen." R7 also stated, "Anytime you pee or shit in your pants it bothers you and it would bother you too. You know they are short and you just get used to it. At the time it makes me feel like a God damn invalid, but it does not make me fester on it daily." On 2/12/15, at 1:49 p.m. nursing assistant (NA)-A stated R7 was usually continent of bladder and bowel and never wore incontinent products. NA-A stated R7 was capable of using the call light and making needs known. NA-A reported R7 required staff assist of one and a mechanical standing lift for transferring onto the toilet when R7 needed to have a bowel movement. NA-A stated R7 was able to use the urinal independently. NA-A confirmed R7 had	F 241		

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F 241	Continued From page 5 experienced episodes of bowel incontinence while waiting for the call light to be answered. NA-A also confirmed R7 had on multiple occasions used his personal cell phone to call the nurses station to request help and then the nurse would go find a nursing assistant to assist R7 which took even longer. NA-A stated R7 was alert and knew what was going on and wrote everything down. NA-A stated R7 used his call light appropriately and when on would go a half hour or longer without being answered. NA-A stated she felt bad when R7 was incontinent of bowel because of the long wait and was always very apologetic and embarrassed. NA-A also stated it was frustrating to come to the facility because staff felt they could not do their jobs because there was not enough staff and it felt like we were neglecting the needs of the residents. NA-A added, as caregivers they form bonds with the residents. During interview on 2/12/15, at 2:13 p.m. NA-B stated R7 independently used the urinal, required assist of one staff and the mechanical standing lift to get onto the toilet for bowel movements and R7 was usually continent of bladder and bowel. NA-B confirmed R7 had an incontinent bowel episode due to staff not responding to the call light timely. NA-B stated she had just come to work and had to help R7 get cleaned up, NA-B stated she could tell in R7's voice he was upset, then stated R7 was able to do a lot of his cares by himself and was never incontinent and having to be cleaned up was not dignified. NA-B stated R7 was very easy going, always had jokes to tell and was normally a pretty happy guy.	F 241		

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F 241	Continued From page 6 During interview on 2/13/15, at 9:34 a.m. licensed practical nurse (LPN)-A stated R7 was continent of bladder and bowel. LPN-A stated she did recall R7 reporting to her he was upset about having an incontinent bowel movement while having to wait for staff to help him to the bathroom and stated R7 talked about it for a long time. During interview on 2/13/15, at 9:43 a.m. the director of nursing (DON) stated she was not aware of R7's episodes of bowel incontinence related to staff not answering the call light timely. The DON confirmed R7 was usually continent of bladder and bowel and required staff assistance for toileting. The DON stated, "clearly" staff are expected to care for residents in a dignified manner including timely toileting to avoid incontinent episodes. The facility's Resident's Rights Dignity policy, dated July 2006, revised October 2009, indicated staff would treat residents with dignity and respect that maintained and enhanced each resident's self-worth and improved his or her psychosocial well-being and quality of life.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242	F242 1. Resident #7 is receiving a bath/shower per choice. 2. Immediately re -assessed each resident's bathing preference. 3. Re-train staff on resident rights and choices. 4. Random audits of resident satisfaction per LSW/RNAC/Department Heads/Designee. Review at QAPI if problem identified.	3-25-15

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F 242	Continued From page 7 are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide residents the opportunity to choose the type of bath they preferred for 1 of 1 resident (R7) reviewed with concerns regarding these choices. Findings include: R7's quarterly Minimum Data Set (MDS) dated 12/5/14, indicated R7 was cognitively intact and had the following diagnoses: body myositis (a neuromuscular disorder), depression and osteoarthrosis. The MDS indicated R7 required physical assist of one staff with transfers, toileting, dressing and bathing. During interview on 2/11/15, at 11:34 a.m. R7 reported he was never given a choice regarding bathing options. R7 stated he had only received showers for the past year and a half. R7 reported the facility did have a whirlpool bath and stated it would have felt so good on his muscles to sit and relax in the warm water and bubbles. R7 stated he had mentioned to a staff member that it would be really nice to have a bath sometime and was told by staff they do not use the whirlpool tub. R7 stated he had never requested a bath again after that as he assumed the whirlpool bath was not working, or an option for the residents to use.	F 242		

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F 242	Continued From page 8 During interview on 02/13/15, at 9:06 a.m. R7 stated staff came into his room last night and asked him if he wanted a bath or shower, "first time they ever did that." R7 stated he told them he would like a bath once in a while and then they left my room and he stated he had heard them asking other residents too. During interview on 2/12/15, at 1:49 p.m. nursing assistant (NA)-A stated R7 received one shower per week, on Mondays. NA-A confirmed many residents would prefer to have whirlpool baths but stated staff were unable to provide that choice of bathing to the residents because it took extra time to give a resident a tub bath compared to a shower. NA-A stated currently staff were only capable of giving showers or bed baths to residents, then added, sometimes there isn't even enough time to give showers. During interview on 2/12/15, at 2:13 p.m. nursing assistant (NA)-B stated R7 required assistance of one staff to get into the shower. NA-B stated she had never received education on how to operate the whirlpool jetted bathtub and had never given a resident a bath. NA-B was not sure why the facility was not giving residents the choice of the whirlpool bath. During interview on 2/12/15, at 3:07 p.m. registered nurse (RN)-C stated the facility did have a working whirlpool bath tub and did have a few residents that used it, but not every time. RN-C stated staff would offer a bath to residents as a comfort measure if a resident had a flare up	F 242		

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F 242	Continued From page 9 of arthritis or something like that. RN-C stated there was quite a few years that the facility did not have a working tub, so now the facility was encouraging the nursing assistants to offer that choice to the residents again. RN-C stated the NAs had received training on the use of the whirlpool tub and stated a few of the nurses knew how to use it. During interview on 2/12/15, at 4:08 p.m. the director of nursing (DON) and the administrator both confirmed the facility did not specifically address the education regarding the use of the whirlpool tub in new employee orientation. The DON and the administrator stated bathing was offered to all residents on all three shifts, and could not ensure that all staff had been trained on the use of bathing residents using the whirlpool jetted tub. The administrator stated they could line up education and have that completed right away. During interview on 2/12/15, at 4:20 p.m. licensed social worker (LSW)-A stated with each admission the facility identified each resident's preference regarding bathing and documented on a "tidbit" sheet. LSW-A confirmed the facility did not complete a tidbit sheet to identify the individual preferences for R7 upon admission. On 2/13/15, at 8:55 a.m. LSW-A was observed reviewing R7's completed admission file. LSW-A confirmed the facility had not documented R7 preferences regarding bathing.	F 242		

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F 242	Continued From page 10 The facility's Resident's Rights policy, dated October 2009, would give residents options and preferences regarding care and treatment whenever possible.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure care planned interventions for repositioning were implemented for 2 of 3 residents (R1, R34) reviewed for repositioning. Findings include: R1 was not repositioned as directed by the care plan. R1's quarterly Minimum Data set (MDS) dated 1/9/15, revealed R1 had aphasia (loss of ability to communicate), required total two staff assistance for bed mobility and extensive assist of two staff for transfers. The MDS also indicated R1 was at risk for pressure ulcers, was on a turning and repositioning program and had a pressure reducing device in the bed and wheelchair. R1's care plan, dated 1/22/15, indicated R1 had incontinence of bowel and bladder related to	F 282	**F282** 1. Resident #1 and # 34 are being repositioned timely. 2. Other residents identified as needing assistance with repositioning are receiving care per care plan. 3. Re-educate all staff on importance of timely repositioning and following care plans. 4. Random weekly audits that residents are receiving repositioning per care plan to be completed by charge nurses/clinical manager/designee. Review at QAPI if problem identified.	3-25-15

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F 282	Continued From page 11 immobility and cognitive deficits from traumatic brain injury and was at risk for pressure ulcers. The care plan directed staff to turn and reposition R1 on a schedule as determined by R1's skin assessment to ensure skin would remain intact. R1's comprehensive skin assessment, dated 4/10/14 identified R1 was at "High risk" for pressure ulcers related to factors which included paralysis, incontinence of bowel and bladder and sitting and lying for extended periods of time and indicated R1 required an every two hour repositioning schedule when lying or sitting. On 2/12/15, at 8:09 a.m., R1 was observed seated in a high-backed wheel chair. -At 9:36 a.m. R1 was observed in the same position. -At 9:44 a.m. nursing assistant (NA)-A stated R1 was assisted into the wheelchair at 5:00 a.m. and was last repositioned at 7:45 a.m., a total of two hours and 45 minutes. NA-A confirmed the two hour and 45 minutes time span between repositioning and stated R1 was to be repositioned every two hours to reduce risk of skin breakdown. NA-A stated "sometimes" R1 did not get repositioned every two hours, because R1 was unable to communicate needs. On 2/12/15, at 11:20 a.m. registered nurse (RN)-C confirmed R1's skin assessment and care plan identified R1's risk for the development of pressure ulcers. RN-A verified it would be expected that R1 would have been repositioned every two hours as directed.	F 282		

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F 282	Continued From page 12 On 2/12/15, at 1:42 p.m. the director of nursing (DON) confirmed R1 was at risk for pressure ulcers and stated it was expected that R1 would have been repositioned every two hours according to the care plan. R34 was not repositioned timely as directed by the care plan. R34's quarterly MDS dated 12/19/14, indicated R34 was severely cognitively impaired, required extensive assistance for all activities of daily living (ADL) and had the following diagnoses: heart failure, dementia, cerebrovascular accident (CVA) and hemiparesis. The MDS also indicated R34 required total two staff assistance for bed mobility and extensive assist of two staff and a mechanical lift for transfers. R34's care plan dated 1/1/15, indicated R34 had incontinence of bowel and bladder related to immobility and dementia. The care plan directed staff to turn and reposition R34 as determined by the tissue tolerance assessment. R34's comprehensive skin assessment dated 3/21/14, indicated R34 was at high risk for pressure ulcers and identified R34's tissue tolerance at two hours which indicated R34 required every two hour repositioning when lying or sitting. The typed summary portion of the assessment indicated R34's skin was intact and interventions such as repositioning every two hours while in bed or in the wheelchair was currently in place.	F 282		

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F 282	Continued From page 13 During observation on 2/11/5, at 7:15 a.m. NA-A and NA-G assisted R34 from bed to wheelchair via total mechanical lift. During continuous observation, R34 was observed to remain in the wheelchair until 9:53 a.m. (2 hours and 38 minutes). During the observation, R34 was unable to reposition independently. During interview on 2/13/15, at 10:01 a.m. NA-G confirmed R34 was not repositioned from 7:15 a.m. until 9:53 a.m., and further stated R34 was not able to reposition self in the wheelchair or in bed. NA-G stated R34's skin was very fragile and had open areas in the past. NA-G confirmed R34 should be repositioned every two hours, then pulled out the nursing assistant assignment sheet to verify. NA-G stated staff cannot get to all the residents to reposition everyone on time. During interview on 2/13/15, at 10:23 a.m. RN-C confirmed R34 had an open area on the buttock six months ago and should be turned and repositioned every two hours. During interview on 2/13/15, at 10:24 a.m. the DON confirmed R34 was at risk for pressure ulcers and it was expected that R34 would have been repositioned every two hours to reduce risk of future skin breakdown.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309	**F309** 1. Updated code status on resident #14. 2. Code status of all residents have been reviewed. 3. Review code status quarterly at care conferences and with change of condition. 4. Random chart audits for proper documentation by clinical manager/RNAC/DNS/Designee. Review at QAPI if problem identified.	3-25-15

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F 309	Continued From page 14 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate hospice interventions for advanced directives for 1 of 1 resident (R14) who received hospice care. Findings include: R14's admission Minimum Data Set (MDS) identified a diagnosis of cancer. R14's physician order dated 11/11/14, directed a hospice consult. The consult identified liver cancer with metastasis (spread through other parts of the body), and directed no further oncology treatment with comfort as the only goal in R14's care. R14's physician's orders further included a signed order dated 11/13/14, which directed no cardiac resuscitation or intubation to assist breathing was to be performed. R14's record further revealed a form titled, DNR/DNI (do not resuscitate, do not intubate) request form, dated 11/13/14. The form was signed by R14's primary health care agent and identified agreement to the order for DNR/DNI. R14's record revealed a form in a plastic cover in the front of R14's record titled, Resuscitation Status, Advance Directive Review. The form had	F 309		

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F 309	Continued From page 15 three printed columns labeled, date of review; code status: circle one, if changed, new form needed; and staff signature. The date of review was last identified as 11/12/14. In the code status column, DNR was circled, then crossed out, and full code (CPR and/or intubation was to be performed) was circled. On 2/11/15, at 2:22 p.m. LPN-A and RN-A confirmed the resuscitation form in the plastic cover in the front of R14's record would be the place facility staff would consult for direction should R14 become unresponsive without heartbeat or breathing. On 2/11/15, at 2:12 p.m. RN-C confirmed the resuscitation status form directed staff to perform resuscitation should R14 become unresponsive without heartbeat or breathing. DON also confirmed the form and verified there was a possibility cardiopulmonary resuscitation could have been performed on R14 even though the directive in the order was for DNR/DNI. RN-C and DON further verified the form should have been updated to reflect R14's advanced directive status. A facility policy titled, Advance Directive Review, dated 1/5/15, directed a procedure to ensure the residents' medical records reflected health care decisions as to advanced directives. The policy included guidelines which included the confirmation that the facility had a system in place to quickly identify a resident's code status and that staff would know how to access the information.	F 309	**F314** 1. Residents #1 and #34 are receiving repositioning per care plan. Residents #56 and #57 are no longer at facility. 2. Other residents identified needing assistance with repositioning are receiving care per care plan. 3. Educate staff on updating care plans and nursing assistant care sheets. 4. Random audits to be completed by clinical manager/charge nurses/designee. Review issues at QAPI if problem identified.	3-25-15
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 16 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 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 provide timely repositioning to reduce the risk of pressure ulcer formation for 2 of 3 residents (R1, R34) identified at risk for pressure ulcers. Findings include: R1's quarterly Minimum Data set (MDS) dated 1/9/15, revealed R1 with aphasia (loss of ability to communicate), required total two staff assistance for bed mobility and extensive assist of two staff for transfers. The MDS also indicated R1 was at risk for pressure ulcers, was on a turning and repositioning program and had a pressure reducing device in the bed and wheelchair. R1's Cognitive Loss/Dementia and Communication Care Area Assessment (CAA), both dated 4/25/14, revealed R1 had sustained a traumatic brain injury and spinal cord injury which resulted in permanent inability to verbalize any words.	F 314		

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F 314	Continued From page 17 R1's Pressure Ulcer CAA dated 4/25/14, indicated R1 had limited mobility and incontinence of bowel and bladder. The CAA also indicated R1 had very little independent movements, was able to stand with a standing lift, requited extensive staff assist with bed mobility and transfers and did not ambulate. The CAA indicated R1's skin was intact and staff repositioned him every two hours with weekly skin checks completed by the nurse. R1's care plan dated 1/22/15, identified R1 had incontinence of bowel and bladder related to immobility, cognitive deficits from traumatic brain injury and was at risk for pressure ulcers. The care plan directed staff to turn and reposition R1 as determined by the tissue tolerance assessment (assessment to determine appropriate repositioning needs). R1's comprehensive skin assessment, dated 4/10/14, indicated R1 was at high risk for pressure ulcers and identified R1's tissue tolerance at two hours which indicated R1 required every two hour repositioning when lying or sitting. The typed summary portion of the assessment indicated R1's skin was intact and interventions such as repositioning every two hours while in bed or in the wheelchair was currently in place. R1's quarterly Interdisciplinary Resident Review dated 10/8/14, revealed R1 had no current pressure ulcers, however, indicated R1 was at risk for pressure ulcers and staff were to reposition R1 every two hours while in bed and	F 314		

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F 314	Continued From page 18 wheel chair. On 2/12/15, at 8:09 a.m. R1 was observed seated in a high-backed wheel chair. -At 9:36 a.m. R1 was observed in the same position. -At 9:44 a.m. nursing assistant (NA)-A stated R1 was assisted into the wheelchair at 5:00 a.m. and was last repositioned at 7:45 a.m., a total of two hours and 45 minutes. NA-A confirmed the two hour and 45 minute time span between repositioning and verified R1 was to be repositioned every two hours in order to reduce risk of skin breakdown. NA-A stated "sometimes" R1 did not get repositioned every two hours, because R1 was unable to communicate needs. On 2/12/15, at 11:20 a.m. registered nurse (RN)-C confirmed R1's skin assessment and verified R1 was at risk for the development of pressure ulcers. RN-A stated it was expected that R1 be turned and repositioned every two hours as directed in order to reduce skin breakdown. On 2/12/15, at 1:42 p.m. the director of nursing (DON) confirmed R1 was at risk for pressure ulcers and it was expected that R1 would have been repositioned every two hours to reduce risk of skin breakdown.	F 314		

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F 314	Continued From page 19 R34's quarterly Minimum Data set (MDS) dated 12/19/14, indicated R34 was severely cognitively impaired, required extensive assistance for all activities of daily living (ADL) and had the following diagnoses: heart failure, dementia, cerebrovascular accident (CVA) and hemiparesis. The MDS also indicated R34 required total two staff assistance for bed mobility and extensive assist of two staff and a mechanical lift for transfers. The MDS also indicated R34 was at risk for pressure ulcers, was on a turning and repositioning program and had a pressure reducing device in the bed and wheelchair. R34's Pressure Ulcer CAA dated 3/21/14, indicated R34 had limited mobility and incontinence of bowel and bladder. The CAA also indicated R34 needed extensive assistance of two with bed mobility, and was dependent for transfers and toileting, and did not ambulate. The CAA indicated R1's skin was intact and staff repositioned him every two hours with weekly skin checks completed by the nurse. R34's care plan dated 1/1/15, identified R34 had incontinence of bowel and bladder related to immobility and dementia. The care plan directed staff to turn and reposition R34 as determined by the tissue tolerance assessment. R34's comprehensive skin assessment dated 3/21/14, indicated R34 was at high risk for pressure ulcers and identified R34's tissue tolerance at two hours which indicated R34 required every two hour repositioning when lying or sitting. The typed summary portion of the	F 314		

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F 314	Continued From page 20 assessment indicated R34's skin was intact and interventions such as repositioning every two hours while in bed or in the wheelchair was currently in place. During observation on 2/11/5, at 7:15 a.m. NA-A and NA-G assisted R34 from bed to wheelchair via total mechanical lift. During continuous observation, R34 was observed to remain in the wheelchair until 9:53 a.m. (2 hours and 38 minutes). During the observation, R34 was unable to reposition independently. During interview on 2/13/15, at 10:01 a.m. NA-G confirmed R34 was not repositioned from 7:15 a.m. until 9:53 a.m. for 2 hours and 38 minutes, and further stated R34 was not able to reposition self in wheelchair or bed. NA-G stated R34's skin was very fragile and had open areas in the past. NA-G confirmed R34 should be repositioned every two hours, then pulled out the nursing assistant assignment sheet to verify. NA-G stated staff could not get to all the residents in order to reposition everyone on time. During interview on 2/13/15, at 10:23 a.m. registered nurse (RN)-C confirmed R34 had a history of open area on the buttocks and should be turned and repositioned every two hours. During interview on 2/13/15, at 10:24 a.m. the DON confirmed R34 was at risk for pressure ulcers and it was expected that R34 would have been repositioned every two hours to reduce risk of future skin breakdown.	F 314		

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F 314	Continued From page 21 The facility policy titled, Skin Care Guidelines, revised 2/25/10, indicated a positioning schedule would be initiated to meet individual resident needs and minimize concentrated pressure to skin.	F 314		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient	F 353	**F353** 1. Scheduling sufficient staff to meet resident #1 and # 34. Residents #56 and # 57 are no at longer at facility. 2. Addressing staffing patterns by making changes as needed based on all resident needs. 3. Facility to re-establish a Recruitment and Retention Committee. 4. Random direct care audits and interviews that care and services are being provided sufficiently by clinical manager/charge nurse/DNS/Designee. Review issues at QAPI if problem identified.	3.25.15

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F 353	Continued From page 22 qualified nursing staff were available to meet resident needs for nursing care in a manner which promoted each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 49 residents residing in the facility. Findings include: The facility failed to provide timely toileting assistance for 1 of 1 resident (R7) resulting in bowel incontinence. Refer to F241. The facility failed to provide timely turning and repositioning services according to the individual assessed need for 2 of 3 residents (R1, R34) as directed by the individual care plans. Refer to F314 and F282. Review of the call light audits dated 10/20/14, indicated resident R56's call light was put on at 12:45 p.m. and answered at 1:20 p.m., a wait time of 35 minutes. The audit indicated R56 had summoned for assistance to go to the bathroom in which he required two staff assistance and the use of a mechanical lift for transfers. Refer to F241. During further review of the call light audits dated 11/13/14, indicated R57's call light was put on at 2:59 p.m. and answered at 3:30 p.m., a wait time of 31 minutes. The audit further indicated R57 had summoned assistance due to complaints of shortness of breath.	F 353		

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F 353	Continued From page 23 On 2/12/15, at 11:18 a.m. during review of staffing schedules for nursing assistants from 8/7/14 to 1/31/15, indicated the following open shifts in which no regular scheduled staff were identified to have had worked the individual open day shift, evening shift and night shifts. Various Open Shifts Available: days, evening and nights -8/7/14 to 8/31/14: 73 shifts open -9/1/14 to 9/30/14: 67 shifts open -10/1/14 to 10/31/14: 57 shifts open -11/1/14 to 11/30/14: 33 shifts open -12/1/14 to 12/31/14: 39 shifts open -1/1/15 to 1/31/15: 37 shifts open On 2/12/15, at 11:18 a.m. during review of staffing schedules for licensed nurses from 8/1/14 to 1/31/15, indicated the following open shifts in which no regular scheduled staff were identified to have had worked the individual open day shift, evening shift and night shifts. Various Open Shifts Available: days, evening and nights -8/1/14 to 8/31/14: 31 shifts open -9/1/14 to 9/30/14: 17 shifts open -10/1/14 to 10/31/14: 32 shifts open -11/1/14 to 11/30/14: 28 shifts open -12/1/14 to 12/31/14: 27 shifts open -1/1/15 to 1/31/15: 42 shifts open During interview on 2/11/15, at 7:50 a.m. nursing assistant (NA)-A stated "we are short everyday of the week, we are always short." NA-A stated staff worked 12 hour shifts due to staffing shortages.	F 353		

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F 353	Continued From page 24 NA-A also stated that after already working a 12 hour shift she had been told she would have to work longer for a total of 16 plus hours due to the next shift being short staffed. NA-A stated they used to have five NAs working the day shift on the skilled level side of the facility which included two NAs on each end and the restorative aid would float back and forth, and now they have only have two NAs working on the skilled side and they had not had a restorative aid for years. NA-A stated they used to have four NAs on the evening shift and now they only have two NAs. NA-A stated the night shift staff consisted of one NA and one licensed nurse for the skilled side which also included the board/care side. NA-A confirmed that that when she went on break there was no one to answer her call lights so when she returned from break the residents were mad. NA-A verified R7 had bowel accidents in his pants due to the long wait time for help. NA-A stated the nurses did not help with call lights and only helped with the State survey agency was present. NA-A stated the facility had been trying to call everyone to come into work because "you are here" [surveyors]. NA-A verified this evening shift had only two NAs scheduled to work and added, "we don't even have the people to take care of the residents and yet we are told its all about resident care." NA-A added, "when we try to talk to management about it, they tell us we have an attitude and then we get into trouble." NA-A confirmed staff get "frozen" (meaning mandated to work later) into the next shift for staff shortages. During interview on 2/11/15, at 8:27 a.m. licensed practical nurse (LPN)-A verified the facility did not have enough staff to cover all the open shifts and	F 353		

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F 353	Continued From page 25 had to have other employees come from other facilities to help. LPN-A added, "They do not have the help." LPN-A stated she was scheduled to work until 10:00 a.m. today, but was told she had to stay because the surveyors were here. LPN-A stated if she would have went home at 10:00 a.m. as scheduled, that would have left one nurse for the whole east and west wing of the nursing home. LPN-A stated they used to have three NAs, two nurses and a restorative aid working but verified they had been working with one NA on each wing and a nurse would try to help them with cares. During interview on 2/11/15, at 2:54 p.m. NA-G stated compared to two years ago, the staffing at the facility "is terrible!" NA-G confirmed there was not enough staff to cover all the open shifts. NA-G stated she was "frozen" (mandated to work into the next shift) therefore, had to work until 6:00 p.m. that evening. NA-G verified she could not get her work done, provide all the resident cares time such as repositioning and toileting timely. NA-G added, "My mind is boggling and you feel for the residents." NA-G confirmed she had to work overtime four to five times a pay period and stated "you are always frozen and sometimes I do feel like they [residents] are neglected." NA-G verified R7 has had to wait along time for assistance and staff try to hurry and R7 has had accidents in his pants due to waiting, but they always have to hurry with cares. NA-G added, "I used to feel good about work, now I feel so bad for the residents." NA-G state she had gone to the director of nursing (DON) for help and was told it was due to resident census, so that did not help.	F 353		

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F 353	Continued From page 26 On 2/12/15, at 10:40 a.m. NA-A stated she could not toilet the residents on time and stated after morning cares, some of the residents did not get toileted again until after lunch. NA-A also stated she could not get residents to breakfast on time and feed them, therefore, breakfast was always late, as late as 10:30 a.m. In addition, NA-A stated she was also unable to reposition the residents timely, provide dental hygiene, trim their fingernails and don't have people to give the residents their baths. NA-A added, "We get forced to feel like we are neglecting people here." During interview on 2/12/15, at 10:44 a.m. NA-B confirmed there was not enough staff to cover all the open shifts and stated "staffing is terrible and it is really stressful to come to work because you don't have enough people to help you." NA-B verified she could not get her work done because they had so many residents that required increased level of care that they could not get the residents toileted and repositioned on time. NA-B stated sometimes after morning cares, the residents had to wait until after lunch to get repositioned or toileted again. NA-B stated staff provided cares for the residents that could talk first and the residents that could not talk had to wait to get toileted and repositioned. NA-B stated, "We try but we cant get it all done and when you work 12 hours, you are exhausted." NA-B confirmed she was frozen five to six times a pay period due to open shifts and stated, "sometimes I feel like I am getting burnt out." During interview on 2/12/15, at 11:10 a.m. LPN-B who also worked in the board and care,	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

(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 353	Continued From page 27 confirmed there was not enough staff in the nursing home to cover all the open shifts and stated, "we could use more help." LPN-B verified when she worked in the long term care unit, she could not get all her work done, provide cares and answer call lights and stated, "It is busy compared to over here [board and care] and honestly I have relief when I work over here." LPN-B verified the facility used to have four NAs working a shift then dropped down to three NAs and now they might have two or three NAs working the floor. LPN-B stated, "They try to get people repositioned and toileted but you can't always get it done." In addition, LPN-B stated breakfast was not being served on time because the NAs could not get people to the dining room on time to eat. During interview on 2/12/15, at 11:18 a.m. the director of nursing (DON) confirmed there was not enough staff to cover all the open shifts and stated, "yes we do have issues with staffing and I would like to hire a few more." The DON stated the facility had one weekend that was always short and verified staff were frozen and were mandated to stay late. The DON added, "They don't have a choice." The DON indicated staff picked up extra shifts but they also had to utilize the frozen policy more so than not. The DON stated someday's it felt as though staff were getting burnt out and some days not. The DON verified she had received complaints from staff that the repeated 12 and 16 hour shifts were getting to be too much and also a request to have three NAs on the evening shift. The DON stated staffing was based on facility census only. The DON denied any specific concerns about cares getting done or lack there of, and complaints from	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	02/13/2015

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F 353	Continued From page 28 the residents. The DON verified they had complaints about call lights not being answered in which call lights audits were done which revealed call light response time problems after meals. During interview on 2/12/15, at 1:50 p.m. the DON verified the day shift had two nurses and three NAs scheduled, but when the resident census was up they would have four NAs. The DON verified the evening shift had two nurses and three NAs or sometimes two NAs which then they would freeze the day shift staff and have night staff come in earlier. The DON stated the night shift consisted of one nurse and either one or two NAs for the whole facility. The DON stated the nurse would help if there was only one NA on duty. The DON stated the freeze policy was enforced on a daily basis. The DON also stated when the census dropped, they utilized shorter shifts. The DON stated staffing was based on resident census and resident needs. During interview on 2/12/15, at 2:17 p.m. the administrator denied any specific family or resident concerns of sufficient staffing and stated she believed the facility was "fully staffed" and the nurses worked 12 hours shifts per their personal request. The administrator verified the facility frozen policy and stated a staff person was mandated to stay if there were open shifts or call ins. The administrator confirmed the day shift stayed an additional 4 hours into the evening shift, and the night shift came in 4 hours early to cover the evening open shifts. The administrator verified she had received complaints from staff related to staffing changes when the census was down. The administrator verified when the census	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 29 was down, they had made changes to the schedule and stated they based staffing off the census and the acuity of resident care. The administrator confirmed she had also received complaints in the past about the call lights not being answered and verified call light audits were done and they had tried to "fix it in QAA." In addition, the administrator verified breakfast was served a little late at times and staff should have been offering residents the whirlpool baths as well. On 2/13/15, a facility policy related to staffing was requested and was not provided	F 353		

Rec'd 3/18/15 SD

F241-D

1. Resident #7 is receiving care in a dignified manner Dignity means interactions with residents will maintain and enhance self-esteem and self-worth.
2. All residents are receiving care in a dignified manner. Dignity means interactions with residents will maintain and enhance self-esteem and self-worth.
3. Random call light, care observation and resident interview audits three times a week for six weeks. This will include an audit of timely toileting. Audits to be completed by DNS/Clinical Manager/Designee.
4. Review at QAPI if problem identified

F242 -D

1. Resident #7 is receiving a bath/shower per choice.
2. Immediately re -assessed each resident's bathing preference.
3. Re-train staff on resident rights and choices per policy. Assess resident choices upon admission and quarterly at care conferences.
4. Random audits of resident satisfaction per LSW/RNAC/Department Heads/Designee. Review at QAPI if problem identified.

F282-E

1. Resident #1 and # 34 are being repositioned timely.
2. Other residents identified as needing assistance with repositioning are receiving care per care plan.
3. Re-educate all staff on importance of timely repositioning per skin integrity guidelines and following care plans.
4. Three audits per week on alternating shifts for six weeks that residents are being repositioning per care plan to be

completed by charge nurses/clinical manager/designee. Review at QAPI if problem identified.

F309-E

1. Updated code status on resident #14.
2. Code status of all residents have been reviewed and updated if needed.
3. Educate staff to review code status on admission, at quarterly care conferences and with change of condition.
4. Random chart audits three times a week for six weeks for proper documentation by clinical manager/RNAC/DNS/Designee. Review at QAPI if problem identified.

F314-D

1. Residents #1 and #34 are receiving repositioning per care plan. Residents #56 and #57 are no longer at facility.
2. Other residents identified needing assistance with repositioning are receiving care per care plan.
3. Educate staff on repositioning residents every two hours (per skin integrity guideline) who are unable to independently, update care plans and nursing assistant care sheets.
4. Random audits three times a week for six weeks on alternating shifts to be completed by clinical manager/charge nurses/designee. Audits will include observation of resident, care plans and nursing assistant care sheets. Review issues at QAPI if problem identified.

F353-F

1. Scheduling sufficient staff to meet resident #1 and # 34. Residents #56 and # 57 are no at longer at facility.

2. Continually address staffing patterns by making changes as needed based on all resident acuity and discussing with staff based on resident acuity.
3. Facility to re-establish a Recruitment and Retention Committee to maintain a stable staffing pattern.
4. Random observational care audits and interview with resident/staff three times a week for six weeks that cares and services are being provided sufficiently by clinical manager/charge nurse/DNS/Designee. Review issues at QAPI if problem identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	**2209 UTAH AVENUE BENSON, MN 56215**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety. At the time of this survey, Golden Living Center - Meadow Lane was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Golden Living Center - Meadow Lane is a 1 story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1958, it is an NF2 facility and was determined to be of Type V(000) construction. In 1970, the SNF/NF facility was built that was determined to be of Type II(222) construction. In 1976 an addition was added to connect the SNF/NF building to the NF2 building which was determined to be of Type II(000) construction. Because the original building and the 2 additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a licensed capacity of 62 and had a census of 48 at the time of the survey.	K 000		

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

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.

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

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	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2015**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0808

February 26, 2015

Ms. Brooke Dillon, Administrator
Golden LivingCenter - Meadow Lane
2209 Utah Avenue
Benson, Minnesota 56215

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5313025 and H5313021

Dear Ms. Dillon:

The above facility was surveyed on February 9, 2015 through February 13, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5313021. that was found to be substantiated. 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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

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 Lyla Burkman at the number of email listed above.

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.

Feel free to contact me if you have questions related to this letter / eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5313s15lic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00930	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/9/15, through 2/13/15, surveyors of this Department's staff, visited the above provider and the following licensing orders were 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.	Rec'd 3/23/15 SB

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2 000	Continued From page 1 Certification Program; 1505 Pebble Lake Rd, Suite 300, Fergus Falls, MN 56537. In addition, a complaint investigation was also completed at the time of the recertification survey. An investigation of complaint H5313021 was completed. The complaint was substantiated. Deficiency issued at 0800.	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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		

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2 565	Continued From page 2 by: Based on observation, interview and document review, the facility did not ensure care planned interventions for repositioning were implemented for 2 of 3 residents (R1, R34) reviewed for repositioning. Findings include: R1 was not repositioned as directed by the care plan. R1's quarterly Minimum Data set (MDS) dated 1/9/15, revealed R1 had aphasia (loss of ability to communicate), required total two staff assistance for bed mobility and extensive assist of two staff for transfers. The MDS also indicated R1 was at risk for pressure ulcers, was on a turning and repositioning program and had a pressure reducing device in the bed and wheelchair. R1's care plan, dated 1/22/15, indicated R1 had incontinence of bowel and bladder related to immobility and cognitive deficits from traumatic brain injury and was at risk for pressure ulcers. The care plan directed staff to turn and reposition R1 on a schedule as determined by R1's skin assessment to ensure skin would remain intact. R1's comprehensive skin assessment, dated 4/10/14 identified R1 was at "High risk" for pressure ulcers related to factors which included paralysis, incontinence of bowel and bladder and sitting and lying for extended periods of time and indicated R1 required an every two hour repositioning schedule when lying or sitting. On 2/12/15, at 8:09 a.m., R1 was observed	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 3 seated in a high-backed wheel chair. -At 9:36 a.m. R1 was observed in the same position. -At 9:44 a.m. nursing assistant (NA)-A stated R1 was assisted into the wheelchair at 5:00 a.m. and was last repositioned at 7:45 a.m., a total of two hours and 45 minutes. NA-A confirmed the two hour and 45 minutes time span between repositioning and stated R1 was to be repositioned every two hours to reduce risk of skin breakdown. NA-A stated "sometimes" R1 did not get repositioned every two hours, because R1 was unable to communicate needs. On 2/12/15, at 11:20 a.m. registered nurse (RN)-C confirmed R1's skin assessment and care plan identified R1's risk for the development of pressure ulcers. RN-A verified it would be expected that R1 would have been repositioned every two hours as directed. On 2/12/15, at 1:42 p.m. the director of nursing (DON) confirmed R1 was at risk for pressure ulcers and stated it was expected that R1 would have been repositioned every two hours according to the care plan. R34 was not repositioned timely as directed by the care plan. R34's quarterly MDS dated 12/19/14, indicated R34 was severely cognitively impaired, required extensive assistance for all activities of daily living (ADL) and had the following diagnoses: heart failure, dementia, cerebrovascular accident (CVA) and hemiparesis. The MDS also indicated R34 required total two staff assistance for bed mobility	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
2 565	Continued From page 4 and extensive assist of two staff and a mechanical lift for transfers. R34's care plan dated 1/1/15, indicated R34 had incontinence of bowel and bladder related to immobility and dementia. The care plan directed staff to turn and reposition R34 as determined by the tissue tolerance assessment. R34's comprehensive skin assessment dated 3/21/14, indicated R34 was at high risk for pressure ulcers and identified R34's tissue tolerance at two hours which indicated R34 required every two hour repositioning when lying or sitting. The typed summary portion of the assessment indicated R34's skin was intact and interventions such as repositioning every two hours while in bed or in the wheelchair was currently in place. During observation on 2/11/5, at 7:15 a.m. NA-A and NA-G assisted R34 from bed to wheelchair via total mechanical lift. During continuous observation, R34 was observed to remain in the wheelchair until 9:53 a.m. (2 hours and 38 minutes). During the observation, R34 was unable to reposition independently. During interview on 2/13/15, at 10:01 a.m. NA-G confirmed R34 was not repositioned from 7:15 a.m. until 9:53 a.m., and further stated R34 was not able to reposition self in the wheelchair or in bed. NA-G stated R34's skin was very fragile and had open areas in the past. NA-G confirmed R34 should be repositioned every two hours, then pulled out the nursing assistant assignment sheet	2 565		

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2 565	Continued From page 5 to verify. NA-G stated staff cannot get to all the residents to reposition everyone on time. During interview on 2/13/15, at 10:23 a.m. RN-C confirmed R34 had an open area on the buttock six months ago and should be turned and repositioned every two hours. During interview on 2/13/15, at 10:24 a.m. the DON confirmed R34 was at risk for pressure ulcers and it was expected that R34 would have been repositioned every two hours to reduce risk of future skin breakdown. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies are reviewed, revised as necessary, staff are trained and monitored to assure all residents receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the	2 800		

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2 800	Continued From page 6 residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient qualified nursing staff were available to meet resident needs for nursing care in a manner which promoted each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 49 residents residing in the facility. Findings include: The facility failed to provide timely toileting assistance for 1 of 1 resident (R7) resulting in bowel incontinence. Refer to 1805. The facility failed to provide timely turning and repositioning services according to the individual assessed need for 2 of 3 residents (R1, R34) as directed by the individual care plans. Refer to 0800. Review of the call light audits dated 10/20/14, indicated resident R56's call light was put on at 12:45 p.m. and answered at 1:20 p.m., a wait time of 35 minutes. The audit indicated R56 had summoned for assistance to go to the bathroom in which he required two staff assistance and the use of a mechanical lift for transfers. Refer to	2 800		

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2 800	Continued From page 7 F241. During further review of the call light audits dated 11/13/14, indicated R57's call light was put on at 2:59 p.m. and answered at 3:30 p.m., a wait time of 31 minutes. The audit further indicated R57 had summoned assistance due to complaints of shortness of breath. On 2/12/15, at 11:18 a.m. during review of staffing schedules for nursing assistants from 8/7/14 to 1/31/15, indicated the following open shifts in which no regular scheduled staff were identified to have had worked the individual open day shift, evening shift and night shifts. Various Open Shifts Available: days, evening and nights -8/7/14 to 8/31/14: 73 shifts open -9/1/14 to 9/30/14: 67 shifts open -10/1/14 to 10/31/14: 57 shifts open -11/1/14 to 11/30/14: 33 shifts open -12/1/14 to 12/31/14: 39 shifts open -1/1/15 to 1/31/15: 37 shifts open On 2/12/15, at 11:18 a.m. during review of staffing schedules for licensed nurses from 8/1/14 to 1/31/15, indicated the following open shifts in which no regular scheduled staff were identified to have had worked the individual open day shift, evening shift and night shifts. Various Open Shifts Available: days, evening and nights -8/1/14 to 8/31/14: 31 shifts open -9/1/14 to 9/30/14: 17 shifts open -10/1/14 to 10/31/14: 32 shifts open -11/1/14 to 11/30/14: 28 shifts open	2 800		

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2 800	Continued From page 8 -12/1/14 to 12/31/14: 27 shifts open -1/1/15 to 1/31/15: 42 shifts open During interview on 2/11/15, at 7:50 a.m. nursing assistant (NA)-A stated "we are short everyday of the week, we are always short." NA-A stated staff worked 12 hour shifts due to staffing shortages. NA-A also stated that after already working a 12 hour shift she had been told she would have to work longer for a total of 16 plus hours due to the next shift being short staffed. NA-A stated they used to have five NAs working the day shift on the skilled level side of the facility which included two NAs on each end and the restorative aid would float back and forth, and now they have only have two NAs working on the skilled side and they had not had a restorative aid for years. NA-A stated they used to have four NAs on the evening shift and now they only have two NAs. NA-A stated the night shift staff consisted of one NA and one licensed nurse for the skilled side which also included the board/care side. NA-A confirmed that that when she went on break there was no one to answer her call lights so when she returned from break the residents were mad. NA-A verified R7 had bowel accidents in his pants due to the long wait time for help. NA-A stated the nurses did not help with call lights and only helped with the State survey agency was present. NA-A stated the facility had been trying to call everyone to come into work because "you are here" [surveyors]. NA-A verified this evening shift had only two NAs scheduled to work and added, "we don't even have the people to take care of the residents and yet we are told its all about resident care." NA-A added, "when we try to talk to management about it, they tell us we have an attitude and then we get into trouble." NA-A confirmed staff get "frozen" (meaning mandated	2 800		

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2 800	Continued From page 9 to work later) into the next shift for staff shortages. During interview on 2/11/15, at 8:27 a.m. licensed practical nurse (LPN)-A verified the facility did not have enough staff to cover all the open shifts and had to have other employees come from other facilities to help. LPN-A added, "They do not have the help." LPN-A stated she was scheduled to work until 10:00 a.m. today, but was told she had to stay because the surveyors were here. LPN-A stated if she would have went home at 10:00 a.m. as scheduled, that would have left one nurse for the whole east and west wing of the nursing home. LPN-A stated they used to have three NAs, two nurses and a restorative aid working but verified they had been working with one NA on each wing and a nurse would try to help them with cares. During interview on 2/11/15, at 2:54 p.m. NA-G stated compared to two years ago, the staffing at the facility "is terrible!" NA-G confirmed there was not enough staff to cover all the open shifts. NA-G stated she was "frozen" (mandated to work into the next shift) therefore, had to work until 6:00 p.m. that evening. NA-G verified she could not get her work done, provide all the resident cares time such as repositioning and toileting timely. NA-G added, "My mind is boggling and you feel for the residents." NA-G confirmed she had to work overtime four to five times a pay period and stated "you are always frozen and sometimes I do feel like they [residents] are neglected." NA-G verified R7 has had to wait along time for assistance and staff try to hurry and R7 has had accidents in his pants due to waiting, but they always have to hurry with cares. NA-G added, "I used to feel good about work,	2 800		

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2 800	Continued From page 10 now I feel so bad for the residents." NA-G state she had gone to the director of nursing (DON) for help and was told it was due to resident census, so that did not help. On 2/12/15, at 10:40 a.m. NA-A stated she could not toilet the residents on time and stated after morning cares, some of the residents did not get toileted again until after lunch. NA-A also stated she could not get residents to breakfast on time and feed them, therefore, breakfast was always late, as late as 10:30 a.m. In addition, NA-A stated she was also unable to reposition the residents timely, provide dental hygiene, trim their fingernails and don't have people to give the residents their baths. NA-A added, "We get forced to feel like we are neglecting people here." During interview on 2/12/15, at 10:44 a.m. NA-B confirmed there was not enough staff to cover all the open shifts and stated "staffing is terrible and it is really stressful to come to work because you don't have enough people to help you." NA-B verified she could not get her work done because they had so many residents that required increased level of care that they could not get the residents toileted and repositioned on time. NA-B stated sometimes after morning cares, the residents had to wait until after lunch to get repositioned or toileted again. NA-B stated staff provided cares for the residents that could talk first and the residents that could not talk had to wait to get toileted and repositioned. NA-B stated, "We try but we cant get it all done and when you work 12 hours, you are exhausted." NA-B confirmed she was frozen five to six times a pay period due to open shifts and stated, "sometimes	2 800		

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2 800	Continued From page 11 I feel like I am getting burnt out." During interview on 2/12/15, at 11:10 a.m. LPN-B who also worked in the board and care, confirmed there was not enough staff in the nursing home to cover all the open shifts and stated, "we could use more help." LPN-B verified when she worked in the long term care unit, she could not get all her work done, provide cares and answer call lights and stated, "It is busy compared to over here [board and care] and honestly I have relief when I work over here." LPN-B verified the facility used to have four NAs working a shift then dropped down to three NAs and now they might have two or three NAs working the floor. LPN-B stated, "They try to get people repositioned and toileted but you can't always get it done." In addition, LPN-B stated breakfast was not being served on time because the NAs could not get people to the dining room on time to eat. During interview on 2/12/15, at 11:18 a.m. the director of nursing (DON) confirmed there was not enough staff to cover all the open shifts and stated, "yes we do have issues with staffing and I would like to hire a few more." The DON stated the facility had one weekend that was always short and verified staff were frozen and were mandated to stay late. The DON added, "They don't have a choice." The DON indicated staff picked up extra shifts but they also had to utilize the frozen policy more so than not. The DON stated someday's it felt as though staff were getting burnt out and some days not. The DON verified she had received complaints from staff that the repeated 12 and 16 hour shifts were getting to be too much and also a request to have	2 800		

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2 800	Continued From page 12 three NAs on the evening shift. The DON stated staffing was based on facility census only. The DON denied any specific concerns about cares getting done or lack there of, and complaints from the residents. The DON verified they had complaints about call lights not being answered in which call lights audits were done which revealed call light response time problems after meals. During interview on 2/12/15, at 1:50 p.m. the DON verified the day shift had two nurses and three NAs scheduled, but when the resident census was up they would have four NAs. The DON verified the evening shift had two nurses and three NAs or sometimes two NAs which then they would freeze the day shift staff and have night staff come in earlier. The DON stated the night shift consisted of one nurse and either one or two NAs for the whole facility. The DON stated the nurse would help if there was only one NA on duty. The DON stated the freeze policy was enforced on a daily basis. The DON also stated when the census dropped, they utilized shorter shifts. The DON stated staffing was based on resident census and resident needs. During interview on 2/12/15, at 2:17 p.m. the administrator denied any specific family or resident concerns of sufficient staffing and stated she believed the facility was "fully staffed" and the nurses worked 12 hours shifts per their personal request. The administrator verified the facility frozen policy and stated a staff person was mandated to stay if there were open shifts or call ins. The administrator confirmed the day shift stayed an additional 4 hours into the evening shift, and the night shift came in 4 hours early to cover the evening open shifts. The administrator	2 800		

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2 800	Continued From page 13 verified she had received complaints from staff related to staffing changes when the census was down. The administrator verified when the census was down, they had made changes to the schedule and stated they based staffing off the census and the acuity of resident care. The administrator confirmed she had also received complaints in the past about the call lights not being answered and verified call light audits were done and they had tried to "fix it in QAA." In addition, the administrator verified breakfast was served a little late at times and staff should have been offering residents the whirlpool baths as well. On 2/13/15, a facility policy related to staffing was requested and was not provided SUGGESTED METHOD OF CORRECTION: Facility administration and the director of nursing could utilize employee, resident and family input to evaluate staffing patterns and identify times/ places where those staffing patterns could/should be adjusted and implement those adjustments in order to meet all resident needs in a timely manner. Facility policies and procedures for sufficient staffing could be reviewed/ revised. Pertinent employees could be retrained on those policies/ practices. Audit tools could be developed to observe for timely and complete care, meeting all resident needs as identified in their care plan. The facility's Quality Assessment & Assurance committee could review those findings and develop/ implement corrective actions for any patterns or root/cause determinations for on-going compliance.	2 800		

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2 800	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to coordinate hospice interventions for advanced directives for 1 of 1 resident (R14) who received hospice care. Findings include: R14's admission Minimum Data Set (MDS) identified a diagnosis of cancer. R14's physician order dated 11/11/14, directed a hospice consult. The consult identified liver cancer with metastasis (spread through other parts of the body), and directed no further oncology treatment with comfort as the only goal in R14's care.	2 830		

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2 830	Continued From page 15 R14's physician's orders further included a signed order dated 11/13/14, which directed no cardiac resuscitation or intubation to assist breathing was to be performed. R14's record further revealed a form titled, DNR/DNI (do not resuscitate, do not intubate) request form, dated 11/13/14. The form was signed by R14's primary health care agent and identified agreement to the order for DNR/DNI. R14's record revealed a form in a plastic cover in the front of R14's record titled, Resuscitation Status, Advance Directive Review. The form had three printed columns labeled, date of review; code status: circle one, if changed, new form needed; and staff signature. The date of review was last identified as 11/12/14. In the code status column, DNR was circled, then crossed out, and full code (CPR and/or intubation was to be performed) was circled. On 2/11/15, at 2:22 p.m. LPN-A and RN-A confirmed the resuscitation form in the plastic cover in the front of R14's record would be the place facility staff would consult for direction should R14 become unresponsive without heartbeat or breathing. On 2/11/15, at 2:12 p.m. RN-C confirmed the resuscitation status form directed staff to perform resuscitation should R14 become unresponsive without heartbeat or breathing. DON also confirmed the form and verified there was a possibility cardiopulmonary resuscitation could have been performed on R14 even though the directive in the order was for DNR/DNI. RN-C and DON further verified the form should have been updated to reflect R14's advanced directive status.	2 830		

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2 830	Continued From page 16 A facility policy titled, Advance Directive Review, dated 1/5/15, directed a procedure to ensure the residents' medical records reflected health care decisions as to advanced directives. The policy included guidelines which included the confirmation that the facility had a system in place to quickly identify a resident's code status and that staff would know how to access the information. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies are reviewed, revised as necessary, staff are trained and monitored to assure all residents advance directives are documented and communicated accurately according to the residents preference to all staff including hospice personnel. The director of nursing or designee could conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.	2 905		

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2 905	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning to reduce the risk of pressure ulcer formation for 2 of 3 residents (R1, R34) identified at risk for pressure ulcers. Findings include: R1's quarterly Minimum Data set (MDS) dated 1/9/15, revealed R1 with aphasia (loss of ability to communicate), required total two staff assistance for bed mobility and extensive assist of two staff for transfers. The MDS also indicated R1 was at risk for pressure ulcers, was on a turning and repositioning program and had a pressure reducing device in the bed and wheelchair. R1's Cognitive Loss/Dementia and Communication Care Area Assessment (CAA), both dated 4/25/14, revealed R1 had sustained a traumatic brain injury and spinal cord injury which resulted in permanent inability to verbalize any words. R1's Pressure Ulcer CAA dated 4/25/14, indicated R1 had limited mobility and incontinence of bowel and bladder. The CAA also indicated R1 had very little independent movements, was able to stand with a standing lift, requited extensive staff assist with bed mobility and transfers and did not ambulate. The CAA indicated R1's skin was intact and staff repositioned him every two hours with weekly skin checks completed by the nurse.	2 905		

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2 905	Continued From page 18 R1's care plan dated 1/22/15, identified R1 had incontinence of bowel and bladder related to immobility, cognitive deficits from traumatic brain injury and was at risk for pressure ulcers. The care plan directed staff to turn and reposition R1 as determined by the tissue tolerance assessment (assessment to determine appropriate repositioning needs). R1's comprehensive skin assessment, dated 4/10/14, indicated R1 was at high risk for pressure ulcers and identified R1's tissue tolerance at two hours which indicated R1 required every two hour repositioning when lying or sitting. The typed summary portion of the assessment indicated R1's skin was intact and interventions such as repositioning every two hours while in bed or in the wheelchair was currently in place. R1's quarterly Interdisciplinary Resident Review dated 10/8/14, revealed R1 had no current pressure ulcers, however, indicated R1 was at risk for pressure ulcers and staff were to reposition R1 every two hours while in bed and wheel chair. On 2/12/15, at 8:09 a.m. R1 was observed seated in a high-backed wheel chair. -At 9:36 a.m. R1 was observed in the same position. -At 9:44 a.m. nursing assistant (NA)-A stated R1 was assisted into the wheelchair at 5:00 a.m. and was last repositioned at 7:45 a.m., a total of two hours and 45 minutes. NA-A confirmed the two hour and 45 minute time span between repositioning and verified R1 was to be	2 905		

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2 905	Continued From page 19 repositioned every two hours in order to reduce risk of skin breakdown. NA-A stated "sometimes" R1 did not get repositioned every two hours, because R1 was unable to communicate needs. On 2/12/15, at 11:20 a.m. registered nurse (RN)-C confirmed R1's skin assessment and verified R1 was at risk for the development of pressure ulcers. RN-A stated it was expected that R1 be turned and repositioned every two hours as directed in order to reduce skin breakdown. On 2/12/15, at 1:42 p.m. the director of nursing (DON) confirmed R1 was at risk for pressure ulcers and it was expected that R1 would have been repositioned every two hours to reduce risk of skin breakdown. R34's quarterly Minimum Data set (MDS) dated 12/19/14, indicated R34 was severely cognitively impaired, required extensive assistance for all activities of daily living (ADL) and had the following diagnoses: heart failure, dementia, cerebrovascular accident (CVA) and hemiparesis. The MDS also indicated R34 required total two staff assistance for bed mobility and extensive assist of two staff and a mechanical lift for transfers. The MDS also indicated R34 was at risk for pressure ulcers, was on a turning and repositioning program and had a pressure reducing device in the bed and wheelchair. R34's Pressure Ulcer CAA dated 3/21/14, indicated R34 had limited mobility and incontinence of bowel and bladder. The CAA also	2 905		

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2 905	Continued From page 20 indicated R34 needed extensive assistance of two with bed mobility, and was dependent for transfers and toileting, and did not ambulate. The CAA indicated R1's skin was intact and staff repositioned him every two hours with weekly skin checks completed by the nurse. R34's care plan dated 1/1/15, identified R34 had incontinence of bowel and bladder related to immobility and dementia. The care plan directed staff to turn and reposition R34 as determined by the tissue tolerance assessment. R34's comprehensive skin assessment dated 3/21/14, indicated R34 was at high risk for pressure ulcers and identified R34's tissue tolerance at two hours which indicated R34 required every two hour repositioning when lying or sitting. The typed summary portion of the assessment indicated R34's skin was intact and interventions such as repositioning every two hours while in bed or in the wheelchair was currently in place. During observation on 2/11/5, at 7:15 a.m. NA-A and NA-G assisted R34 from bed to wheelchair via total mechanical lift. During continuous observation, R34 was observed to remain in the wheelchair until 9:53 a.m. (2 hours and 38 minutes). During the observation, R34 was unable to reposition independently. During interview on 2/13/15, at 10:01 a.m. NA-G confirmed R34 was not repositioned from 7:15 a.m. until 9:53 a.m. for 2 hours and 38 minutes, and further stated R34 was not able to reposition	2 905		

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2 905	Continued From page 21 self in wheelchair or bed. NA-G stated R34's skin was very fragile and had open areas in the past. NA-G confirmed R34 should be repositioned every two hours, then pulled out the nursing assistant assignment sheet to verify. NA-G stated staff could not get to all the residents in order to reposition everyone on time. During interview on 2/13/15, at 10:23 a.m. registered nurse (RN)-C confirmed R34 had a history of open area on the buttocks and should be turned and repositioned every two hours. During interview on 2/13/15, at 10:24 a.m. the DON confirmed R34 was at risk for pressure ulcers and it was expected that R34 would have been repositioned every two hours to reduce risk of future skin breakdown. The facility policy titled, Skin Care Guidelines, revised 2/25/10, indicated a positioning schedule would be initiated to meet individual resident needs and minimize concentrated pressure to skin. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff on ensuring each resident receives turning and repositioning assistance according to their assessed need. The DON or designee could then perform observational audits to determine compliance.	2 905		

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2 905	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 905		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete employee tuberculosis (TB) symptomology screening and/or tuberculin skin testing (TST) for 3 of 5 newly hired employees (NA-C, NA-D, NA-E) as required. In addition, the facility failed to complete TB symptomology screening for 1 of 5 residents (R45) as required.	21426		

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21426	Continued From page 23 Findings include: Employee: Nursing assistant (NA)-C employee file indicated a hire date of 12/9/14. NA-C's Employee Tuberculosis Screening form was blank along with the first and second step TSTs section. There was no evidence these had been administered. NA-D's employee file indicated a hire date of 1/13/15. NA-D's Employee Tuberculosis Screening form was blank along with the first and second step TSTs section. There was no evidence these had been administered. NA-E's employee file indicated a hire date of 12/22/14. NA-E's Employee Tuberculosis Screening form was completed 12/22/14, along with the first step TST. There was no evidence a second step TST had been administered. Resident: R45's medical record indicated an admission date of 9/28/2013. The Tuberculosis Screening form was blank. On 2/11/2015, at 12:30 p.m. RN-C confirmed that R45's TB screening was blank and that it should have completed. On 2/12/2015, at 11:11 a.m. the business	21426		

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21426	Continued From page 24 manager who provided the new employee list and TST records stated there were no records available for NA-C or NA-D. The facility policy titled Tuberculosis Exposure Control Plan dated 12/98, indicated all new admission, new associates, and volunteers will receive a 2-step Mantoux PPD Test. Step I to be administered on admission or on hire, step II to be administered 7-10 days after step I. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to completing employee and resident TB screening according to CDC guidelines. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide dignified care related to	21805		

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21805	Continued From page 25 timely toileting assistance for 1 of 1 resident (R7) reviewed for dignity. Findings include: R7's quarterly Minimum Data Set (MDS) dated 12/5/14, indicated R7 was cognitively intact and had the following diagnoses: body myositis (a neuromuscular disorder), depression, osteoarthrosis, glaucoma and ulcerative colitis (inflamed colon). The MDS indicated R7 required extensive assistance with transfers, toileting and dressing. Further, the MDS identified R7 was always continent of bladder and bowel. R7's care plan revised on 6/17/14, identified R7 had a functioning deficit related to mobility impairments caused by body myositis and potential vision limitations. The care plan identified R7 required assistance of one staff and a mechanical standing lift to transfer to and from the toilet as requested by resident. During interview on 2/11/15, at 11:54 a.m. R7 stated the facility needed to have more staff on the floor to meet the needs of the residents. R7 stated approximately seven months ago he put the call light on at 10:00 a.m. to request assistance to use the bathroom and a nursing assistant came in right away, shut the call light off, told R7 she would let another staff member know he needed help and left the room. R7 stated he waited 10 minutes before he pushed the call light again and then waited another 45 minutes for staff response after that. R7 stated after waiting for another 55 minutes to use the toilet, the same nursing assistant came into his room that came in and shut off his light in the very	21805		

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21805	Continued From page 26 beginning. R7 stated when the nursing assistant entered his room he told her he should not have to wait for a "God damn hour." R7 stated the nurse then entered his room and informed R7 he should not talk to the nursing assistant like that. R7 stated he informed the nurse that he should not have to wait for a whole hour to go the bathroom because staff take their break. R7 stated he told the nurse he had a bowel movement in bed while waiting for staff to help him. R7 stated it aggravated him that he had an accident in the bed and then had to lay in bed for an hour waiting for help. R7 stated there was no reason for it. During the same interview, R7 reported that two months ago his call light was on for 30 minutes while he waited for assistance to use the bathroom so he called the nursing home with his personal phone in order to get staff's attention. R7 stated a nurse answered the phone right away and R7 stated he had identified himself and told the nurse he was going to "shit" his pants because no one would answer his call light and help him to the bathroom. R7 stated after the phone call staff finally made it to his room to assist him, but it was too late, he had already gone to the bathroom in his pants. R7 stated it made him feel bad. In addition, R7 stated on 2/7/15, at 4:45 a.m. he had put the call light on to use the bathroom. R7 stated the call light was not answered until 5:10 a.m. and at that point he had yelled out to the nurse that he had to go to the bathroom. R7 stated by the time staff got in to help him he had already gone in the bed. R7 stated staff are sorry they cannot get in to help him in time and stated	21805		

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21805	Continued From page 27 the nurses helped the nursing assistants as much as they could, but they didn't like it. R7 stated some staff worked for 16 hours at a time, they call it "being frozen." R7 also stated, "Anytime you pee or shit in your pants it bothers you and it would bother you too. You know they are short and you just get used to it. At the time it makes me feel like a God damn invalid, but it does not make me fester on it daily." On 2/12/15, at 1:49 p.m. nursing assistant (NA)-A stated R7 was usually continent of bladder and bowel and never wore incontinent products. NA-A stated R7 was capable of using the call light and making needs known. NA-A reported R7 required staff assist of one and a mechanical standing lift for transferring onto the toilet when R7 needed to have a bowel movement. NA-A stated R7 was able to use the urinal independently. NA-A confirmed R7 had experienced episodes of bowel incontinence while waiting for the call light to be answered. NA-A also confirmed R7 had on multiple occasions used his personal cell phone to call the nurses station to request help and then the nurse would go find a nursing assistant to assist R7 which took even longer. NA-A stated R7 was alert and knew what was going on and wrote everything down. NA-A stated R7 used his call light appropriately and when on would go a half hour or longer without being answered. NA-A stated she felt bad when R7 was incontinent of bowel because of the long wait and was always very apologetic and embarrassed. NA-A also stated it was frustrating to come to the facility because staff felt they could not do their jobs because there was not enough staff and it felt like we were neglecting the needs of the residents. NA-A added, as caregivers they form bonds with	21805		

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21805	Continued From page 28 the residents. During interview on 2/12/15, at 2:13 p.m. NA-B stated R7 independently used the urinal, required assist of one staff and the mechanical standing lift to get onto the toilet for bowel movements and R7 was usually continent of bladder and bowel. NA-B confirmed R7 had an incontinent bowel episode due to staff not responding to the call light timely. NA-B stated she had just come to work and had to help R7 get cleaned up, NA-B stated she could tell in R7's voice he was upset, then stated R7 was able to do a lot of his cares by himself and was never incontinent and having to be cleaned up was not dignified. NA-B stated R7 was very easy going, always had jokes to tell and was normally a pretty happy guy. During interview on 2/13/15, at 9:34 a.m. licensed practical nurse (LPN)-A stated R7 was continent of bladder and bowel. LPN-A stated she did recall R7 reporting to her he was upset about having an incontinent bowel movement while having to wait for staff to help him to the bathroom and stated R7 talked about it for a long time. During interview on 2/13/15, at 9:43 a.m. the director of nursing (DON) stated she was not aware of R7's episodes of bowel incontinence related to staff not answering the call light timely. The DON confirmed R7 was usually continent of bladder and bowel and required staff assistance for toileting. The DON stated, "clearly" staff are expected to care for residents in a dignified manner including timely toileting to avoid	21805		

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21805	Continued From page 29 incontinent episodes. The facility's Resident's Rights Dignity policy, dated July 2006, revised October 2009, indicated staff would treat residents with dignity and respect that maintained and enhanced each resident's self-worth and improved his or her psychosocial well-being and quality of life. SUGGESTED METHOD OF CORRECTION: The director of nursing or social services could in-service all staff on the need to treat all residents with respect and dignity. The Quality Assessment and Assurance committee could develop a system to audit employees for dignified care and services toward residents in the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be	21830		

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present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

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

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

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or

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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
21830	Continued From page 31 designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide residents the opportunity	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00930	A. BUILDING: _____ B. WING _____	02/13/2015

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21830	Continued From page 32 to choose the type of bath they preferred for 1 of 1 resident (R7) reviewed with concerns regarding these choices. Findings include: R7's quarterly Minimum Data Set (MDS) dated 12/5/14, indicated R7 was cognitively intact and had the following diagnoses: body myositis (a neuromuscular disorder), depression and osteoarthrosis. The MDS indicated R7 required physical assist of one staff with transfers, toileting, dressing and bathing. During interview on 2/11/15, at 11:34 a.m. R7 reported he was never given a choice regarding bathing options. R7 stated he had only received showers for the past year and a half. R7 reported the facility did have a whirlpool bath and stated it would have felt so good on his muscles to sit and relax in the warm water and bubbles. R7 stated he had mentioned to a staff member that it would be really nice to have a bath sometime and was told by staff they do not use the whirlpool tub. R7 stated he had never requested a bath again after that as he assumed the whirlpool bath was not working, or an option for the residents to use. During interview on 02/13/15, at 9:06 a.m. R7 stated staff came into his room last night and asked him if he wanted a bath or shower, "first time they ever did that." R7 stated he told them he would like a bath once in a while and then they left my room and he stated he had heard them asking other residents too.	21830		

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21830	Continued From page 33 During interview on 2/12/15, at 1:49 p.m. nursing assistant (NA)-A stated R7 received one shower per week, on Mondays. NA-A confirmed many residents would prefer to have whirlpool baths but stated staff were unable to provide that choice of bathing to the residents because it took extra time to give a resident a tub bath compared to a shower. NA-A stated currently staff were only capable of giving showers or bed baths to residents, then added, sometimes there isn't even enough time to give showers. During interview on 2/12/15, at 2:13 p.m. nursing assistant (NA)-B stated R7 required assistance of one staff to get into the shower. NA-B stated she had never received education on how to operate the whirlpool jetted bathtub and had never given a resident a bath. NA-B was not sure why the facility was not giving residents the choice of the whirlpool bath. During interview on 2/12/15, at 3:07 p.m. registered nurse (RN)-C stated the facility did have a working whirlpool bath tub and did have a few residents that used it, but not every time. RN-C stated staff would offer a bath to residents as a comfort measure if a resident had a flare up of arthritis or something like that. RN-C stated there was quite a few years that the facility did not have a working tub, so now the facility was encouraging the nursing assistants to offer that choice to the residents again. RN-C stated the NAs had received training on the use of the whirlpool tub and stated a few of the nurses knew how to use it.	21830		

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21830	Continued From page 34 During interview on 2/12/15, at 4:08 p.m. the director of nursing (DON) and the administrator both confirmed the facility did not specifically address the education regarding the use of the whirlpool tub in new employee orientation. The DON and the administrator stated bathing was offered to all residents on all three shifts, and could not ensure that all staff had been trained on the use of bathing residents using the whirlpool jetted tub. The administrator stated they could line up education and have that completed right away. During interview on 2/12/15, at 4:20 p.m. licensed social worker (LSW)-A stated with each admission the facility identified each resident's preference regarding bathing and documented on a "tidbit" sheet. LSW-A confirmed the facility did not complete a tidbit sheet to identify the individual preferences for R7 upon admission. On 2/13/15, at 8:55 a.m. LSW-A was observed reviewing R7's completed admission file. LSW-A confirmed the facility had not documented R7 preferences regarding bathing. The facility's Resident's Rights policy, dated October 2009, would give residents options and preferences regarding care and treatment whenever possible. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures regarding resident choices, educate staff, and conduct audits to ensure resident likes,	21830		

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21830	Continued From page 35 dislikes and routines are followed by staff. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21830		