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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: URDS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

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

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

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

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

6. DATE OF SURVEY **12/19/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A,5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 02/05/2014 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

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

DETERMINATION APPROVAL

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

CCN-24-5222

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5222

March 12, 2014

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

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

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

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

69 Skilled Nursing Facility/Nursing Facility Beds

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

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

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 5, 2014

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

RE: Project Number S5520024

Dear Mr. Onstad:

On November 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 7, 2013, effective December 17, 2013 and therefore remedies outlined in our letter to you dated November 26, 2013, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K-0067 at the time of the November 7, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245222	A. Building B. Wing	12/19/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0155** Reg. # **483.10(b)(4)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **12/17/2013**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/17/2013**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **12/17/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	02/05/2014	18623	12/19/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: URDS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**

2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

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

4. TYPE OF ACTION: **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 **11/07/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 5 *** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jonathan Hill, HFE NE II 12/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 2/24/14 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN-24-5222

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

Documentation supporting the facility's request for a continuing waiver involving K67 was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7425

November 26, 2013

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

RE: Project Number S5222023

Dear Mr. Onstad:

On November 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by NO DATA, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 7, 2014 (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 May 7, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Larson, Monica (MDH)

From: Meath, Mark (MDH)
Sent: Monday, February 24, 2014 3:55 PM
To: Larson, Monica (MDH)
Subject: DONE with CMS 1539 for GLC Chateau

Importance: High

THANK YOU.

MARK MEATH, ENFORCEMENT SPECIALIST
PROGRAM ASSURANCE UNIT
LICENSING AND CERTIFICATION PROGRAM
DIVISION OF COMPLIANCE MONITORING
85 EAST SEVENTH PLACE, SUITE 220
P.O. BOX 64900
ST. PAUL, MN 55164-0900
TELEPHONE: (651) 201-4118 FAX: (651) 215-9697
EMAIL: MARK.MEATH@STATE.MN.US

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	11/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	RECEIVED DEC 12 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Accepted 12-13 Lynn Dostert	

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

EXECUTIVE DIRECTOR 12/10/2013

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

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	245222	A. BUILDING _____ B. WING _____	11/07/2013

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

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F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure the risks and benefits were addressed and provided to the resident and/or representative when a Dynasplint (a splint that stretched joints that are lacking range of motion) was refused to be donned for 1 of 1 resident (R24) who had a contracture of the right elbow/hand. Findings include: On 11/4/13, at 6:02 p.m. R24 was observed to be in a tilting wheelchair in her room. R24's right knee, elbow, wrist, hand and fingers were visibly contracted. R24 was not observed to be wearing a splint at the time of the observation. On 11/5/13, at 3:25 p.m. R24 was randomly observed to be in bed with no splint applied. On 11/6/13, during observations from 7:34 a.m. through 10:18 a.m. the following was observed and at no time was there a splint applied to R24'sright hand, elbow, wrist and fingers. - At 8:11 a.m. NA-F visually laid eyes on R24, and then quickly left the day room. When asked if she received range of motion to her right arm, R24 stated, "No." When asked if she did her own exercises or tried to straighten out her own arm (do own her range of motion) R24 moved her left arm and straightened it, then took the right hand and lifted it slightly. When asked if she ever wore a splint or brace on her arm, R24 shook her head, "No." - At 9:10 a.m. NA-F stated she did not assist R24	F 155	F155 • The guardian of R24 and R24 has been provided verbal and written information regarding a resident's right to accept or refuse medical treatment including risks and benefits range of motion programs and splint wearing schedules. • All residents with ROM or splinting programs will be audited for compliance and those residents and/or legal representatives will be provided verbal and written risks and benefits if they are refusing to participate. • Nursing Staff will be educated on policy for Advanced Directives and the right to refuse treatments. • The Director of Nursing Services (DNS) or designee will observe 2 resident's range of motion cares per week and ensure risks and benefits are provided appropriately for any resident that refuses to participate. • DNS will report results of audits to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS will be responsible. • Completion date: December 17, 2013.	

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F 155	Continued From page 2 with morning cares and R24 was assisted by the night shift staff. NA-F then did approximately four to five passive range of motion (PROM) repetitions to R24's leg and knee. NA-F then attempted to provide PROM to R24's right elbow, R24 hit at NA-F with her left hand twice. NA-F redirected R24, but the resident would not allow ROM. NA-F stopped the PROM (no PROM was provided to wrist or hand). - At 9:28 a.m. NA-F stated R24 "was able to move her left (side of the body) fine." NA-F stated she usually completed five to 10 repetitions of PROM on the right upper and lower extremity. - At 9:32 a.m. after surveyor questioned if R24 had a splint, NA-F retrieved a splint from the top drawer of the bedside stand. NA-F attempted to open R24's right hand and apply the splint. R24 called out "Ow!" twice. NA-F was unable to open R24's right hand to apply the splint. R24 appeared calm, but would not allow NA-F to apply the splint by gently pushing NA-F's hands away. NA-F stated she "occasionally could not apply the splint," but stated it was usually due to R24 pushing her away. During the observation, NA-F was unable to straighten R24's right ring and pinky finger, but was able to slightly open the rest of R24's hand. R24's hand would not form over the palm aspect of the splint. NA-F stated the refusal should be reported to the nurse and stated she would re-attempt to apply the splint. NA-F explained when R24 refused, staff was to re-approach, use different staff to re-approach and to report to the nurse was the procedure nursing assistant staff was to follow for refusals. NA-F was unclear when the splint should be applied and was unclear if R24 had more than one splint. - At 9:52 a.m. TMA-A stated she was unaware of the refusal and referred the surveyor to RN-D.	F 155		

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F 155	Continued From page 3 RN-D was present nearby and verified no staff had approached her regarding R24's refusals of PROM or wearing a splint. No splint was applied and PROM of the upper extremity was not re-attempted for R24 during the observations. On 11/6/13, at 12:40 p.m. RN-D stated she completed the ROM on R24 prior to the observation of her completing ROM with a male resident. RN-D stated ROM was done "before [R24] got out of bed." RN-D explained the splint in the room was for the "night shift" and should be applied when R24 was in bed. RN-D stated the "Dynasplint was broken." At the time of the interview, RN-A was present and verified the Dynasplint was broken and "had been sent back to the company." RN-A stated occupational therapy was involved with sending the splint back and was aware of the Dynasplint being broken. RN-D and RN-A verified, if R24 refused the splint or ROM, the refusal should be reported. Both RNs stated staff should re-approach and/or try a different staff when R24 refuses. RN-D was not clear if R24's PROM was usually completed by the NA staff or nursing. - At 1:17 p.m. the occupational therapist (OT)-A stated R24 "was on case load [being seen for occupational therapy]," but not for splinting or ROM. OT-A stated she did not write down when the Dynasplint was broken, but verified she was notified and called the company to have it fixed. OT-A stated she was unclear when the Dynasplint broke, but believed it was "approximately 1 1/2 - 2 weeks ago." OT-A stated the splint had broken "again" and they were now waiting to have it fixed. OT-A stated she offered to have the Dynasplint repaired when she heard it was broken but, "Because she [R24] wasn't on case load [at the time], I didn't record all that	F 155		

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F 155	Continued From page 4	F 155		

information." OT-A verified R24 had a functional maintenance program for splinting and ROM when she "came off case load."
- At 1:28 p.m. OT-A stated R24 was picked up on case load on 9/18/12, for contracture management and R24's last day of occupational therapy was on 11/30/12. OT-A provided a copy of the Nursing Program (functional maintenance program, FMP) dated 11/28/12. Both the FMP and OT-A indicated the Dynasplint was to be applied twice daily for an hour each time. A second contour hand splint was to be applied two hours twice daily "as R24 tolerates." The FMP directed to complete PROM of shoulder, elbow, wrist and hand before applying the splint.
- At 1:35 p.m. OT-A verified the measurements of R24's contracture's at the end of therapy were: right elbow - 70 degrees flexion; right wrist extension contracture's with passive flexion - limited to zero degrees; right hand digits three through five demonstrated flexion contracture's at 90 degree for third digit, 60 degrees for digits four and five, second digit and thumb within functional limits. OT-A stated R24 was refusing to wear and taking off the splints while she was receiving therapy and R24 would "give permission to apply [the splint], but then would take off the splint." OT-A stated R24 did not require pain medication prior to PROM or splinting. OT-A stated although the splints may have been refused, the PROM program may prevent progression of the contractures.
- At 1:46 p.m. OT-A approached R24 to measure her contracture's. R24 initially agree to allow the measurement. OT-A slowly attempted to straighten R24's right arm and elbow, R24 denied pain and the contracture was measured at 95 degrees flexion. OT-A stated "that's not better." R24's wrist was measured at zero. R24 pushed

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F 155	Continued From page 5 OT-A away, would not answer when asked if she had pain. OT-A verified R24's elbow contracture "was getting tighter." R24 would not allow OT-A to measure the hand or finger contracture's. The care plan for physical functioning dated as revised on 7/4/11, identified R24's risk factors of TBI, hemiplegia and R24 was admitted with contracture's of bilateral lower extremities; R24 was identified to have hemiparesis and contracture of the right arm. R24 was identified as requiring total assistance with all activities of daily living (ADLs), including dressing and grooming. The care plan directed to provide PROM exercises to legs and arms daily twice daily and to report changes in ROM to the nurse. The care plan directed, "Put dynamic right wrist and splint [on for] 2 hours in the morning and 2 hours in the PM [afternoon or evening]. Followed by PROM to right upper extremity. Two staff for all cares in resident room." The annual Minimum Data Set (MDS) dated 11/7/12, indicated R24 had severely impaired short and long-term memory problems, required total dependence for all ADLs, and R24 was non-ambulatory. R24 was identified to have an impairment of ROM on one side of the upper extremities and both sides of the lower extremities. A Brief Interview for Mental Status was not completed due to R24's cognitive status. The Care Area Assessment (CAA) for cognition dated 11/12/12, identified R24 had impaired short and long-term memory, severely impaired decision making skills and, "Resident also has presentation of psychomotor retardation and has had behavioral symptoms of rejection of cares and physical abuse." The CAA indicated R24's diagnoses included dementia, depression,	F 155		

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F 155	Continued From page 6 traumatic brain injury (TBI) and anxiety. The CAA indicated R24 was "at baseline." The CAA for communication dated 11/12/12, indicated R24 relied on others to identify and meet her needs, indicated R24 was rarely understood and rarely able to understand. The CAA's did not address splinting or ROM. The care plan for behaviors dated as revised 4/15/13, identified physical behaviors towards staff of hitting, pinching, kicking, grabbing or pulling at others hair and R24 was "sometimes resistive to cares." The care plan did not address R24's refusal to wear the Dynasplint or PROM. The care plan did not address a second contour splint. The Quarterly MDS dated 8/7/13, indicated R24 needed extensive assistance with eating, but had not changed in ADLs or cognition from the annual MDS. The quarterly MDS indicated no changes in R24's functional ROM. The social services assessment dated 8/15/13, reviewed R24's social history prior to admission, identified R24 had the behavior of refusing cares and referred to R24's care plan. The clinical record had no further assessment of R24's refusals of cares or status of her contractures. R24's Physician Orders dated 8/29/13, directed splints to the right wrist for two hours in the morning and two hours in afternoon. Physician's Orders dated 10/28/13, indicated occupational therapy was to evaluate and treat R24. Review of R24's IDT Progress Notes from 4/11/13, through 11/5/13, indicated the Dynasplint was "repaired" by a technician on 10/15/13. The	F 155		

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F 155	Continued From page 7 progress notes did not address unavailability of the splint or R24's refusals to wear the splint, and did not address the risks versus benefits of donning the splint. R24's treatment sheets August 2013 through November 2013 indicated the following: - August - R24 did not receive PROM due to refusal, not applied due to "Other" or sleeping 18 times out of 62 opportunities. The treatment sheet indicated R24 had two Dynamic right wrist splints both applied for two hours in morning and "PM." The first splint ordered 12/4/09, was not applied due to refusal or "Other" 31 times out of 62 opportunities. The second splint ordered 1/9/13, was not applied 18 out of 62 opportunities. - September - R24 did not receive PROM 11 times out of 60 opportunities; the first splint was refused or "Other" 33 times out of 60; the second splint was refused or "Other" 24 times out of 60. - October - R24 refused PROM seven times out of 62 opportunities; refused the first splint or "Other" 29 times out of 62 opportunities; the second splint was refused or "Other" 21 times out of 62 opportunities. - November - R24 did not refuse PROM; the first splint was not applied due to "Other" four times out of 12 opportunities; the second splint was not applied due to "Other" two out of 12 opportunities. Review of the clinical record August 2013, forward indicated R24 had a consistent pattern of refusing the Dynasplint. Although the treatment sheets directed two separate splints, the clinical record did not identify the different splints. In addition, the notes regarding refusals did not include attempts to re-approach R24. The clinical record indicated R24's splint was "broken" in November 2013 and October 2013.	F 155		

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F 155	Continued From page 8 Review of the undated NAR (Nursing Assistant/Registered) Assignment 3rd Floor forms (undated and printed off by RN-A at approximately 8:42 a.m. on 11/6/13), directed, "NOC [night] shift to get resident dressed and leave in bed. Put Dynasplint on R [right] arm, leave on for 1 hour. PM shift to put DynaSplint R arm, leave on 1 hour. NAR report to nurse when DynaSplint is on/off." The sheet further directed, "PROM exercises to legs & arms AM/PM." The form did not address the use of another splint. On 11/7/13, at 8:42 a.m. the director of nursing (DON) was notified of a potential decline in R24's ROM. DON stated the OT-A reported the measurements of the elbow contracture to her "yesterday" and verified R24's refusals were documented in the progress notes. DON stated R24 was currently in an "assessment period," but stated there was no documentation R24's refusals were assessed prior to the current MDS assessment period. DON stated the progress notes were read by all the department heads, but was unclear if the refusals were evaluated. DON expressed she was skeptical R24's ROM had declined, as she had "cut [R24's] nails yesterday" and observed her extend her elbow "pretty straight." DON stated staff was aware of R24's refusals and stated staff should re-approach, attempt a different staff and report the refusal to the nurse. DON stated she was unclear R24 had another splint. On 11/7/13, at 9:53 a.m. the social worker (SW)-A stated she was aware of R24's refusals to wear the splints, but was unclear when she was notified of R24's refusal to wear the splint(s), "It was some time ago." SW-A stated she read the	F 155		

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F 155	Continued From page 9 progress notes every morning and verified R24 had no assessment of her refusals. Although SW-A verified the social services department wrote the CAA for behaviors and wrote the care plan for behaviors, SW-A stated the nursing department was responsible for assessing resident refusals. SW-A was unclear if R24's guardian was notified of her refusals to wear the splints or allow PROM, SW-A stated any discussion with the guardian regarding risk and benefits would be completed by nursing. SW-A stated social service involvement was through participation in the interdisciplinary team (IDT) process, and the social service role was to "provide suggestions and ideas" to address behaviors (such as refusals) based on "what we know of the resident." SW-A stated she expected nursing to notify her "if resident where are higher risk [for injury or decline]" and stated she viewed R24 as "lower risk." When asked if she was aware R24's contracture could progress without splinting and ROM, SW-A explained she was unaware of any potential decline in R24's ROM. On 11/7/13, at 10:08 a.m. the DON stated there was no policy on refusals. On 11/7/13, at 12:31 p.m. DON and the administrator stated there was no facility policy for care planning, assessment of behaviors, range of motion, or splinting. DON stated the facility policy for behavior assessment was to follow the RAI (resident assessment instrument) process, care planning per the RAI process and that there was some documentation in the records regarding behaviors done "on all residents" in the facility, regardless of if the resident received a psychoactive medications. DON verified the facility did not complete a root cause evaluation	F 155		

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F 155	Continued From page 10 of behaviors. DON stated staff "look at" the clinical documentation and read the progress notes "daily." On 11/7/13, at 1:22 p.m. R24's guardian was contacted via telephone. The guardian verified she was assigned as R24's guardian since "the beginning of the year" in February 2013 or March 2013. The guardian stated she was aware R24 refused "at times" and verified she was not notified of R24's refusal to wear the Dynasplint, or the that Dynasplint was not functional and not being worn. The guardian stated she was not informed of the risks versus benefits regarding not wearing the Dynasplint. The guardian stated she had a "good rapport" with occupational therapy and in the past was notified by therapy if a resident was going to be discharged (from therapy) because of refusing to participate. The guardian explained R24 had a care conference "coming up soon" and she expected the staff to give her a detailed review of R24. The guardian stated she would be asking staff about that at the care conference and verified she expected to be notified of the refusals. R24 and R24's guardian was not explained the risks versus benefits of refusing the Dynasplint nor was either party provided any written information of the refuasl of the splint.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician	F 157		

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F 157	Continued From page 11 intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure refusals to wear a Dynasplint (a splint that stretch joints that are lacking range of motion) were reported to the guardian and physician for 1 of 1 resident (R24). Findings include: On 11/6/13, during observations from 7:34 a.m. through 10:18 a.m. R24 was observed to have contractures of the right elbow, wrist and hand.	F 157	F 157 • R24 physician was notified of change in ROM and refusals to wear splint or allow ROM at times, during survey. • R24 guardian was notified at care conference on 11/11/13. • All residents on ROM/Splinting programs charts will be reviewed for refusals and documentation that MD and guardians were notified as needed. • Facility Notification of Change in Resident Health Status clinical guideline has been reviewed and revised as needed. • Licensed staff will be educated on the Notification of Change in Resident Health Status guideline. • DNS or designee will audit progress notes at least weekly for compliance to notifying resident's Physician/NP and Legal Representatives. • DNS will report results of audits to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS will be responsible. • Completion date: December 17, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	11/07/2013

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F 157	Continued From page 12 R24 was observed to refuse to wear a contour splint. R24 was observed to refuse passive range of motion (PROM) to the upper body. On 11/6/13, at 12:40 p.m. a registered nurse (RN)-D explained the splint in R24's room was for the "night shift" and should be applied when R24 was in bed. RN-D stated the "Dynasplint was broken." At the time of the interview, the nurse manager (RN)-A was present and verified the Dynasplint was broken and "had been sent back to the company." RN-D and RN-A both verified if R24 refused the splint or ROM, the refusal should be reported. Both RNs stated staff should re-approach and/or try a different staff when R24 refuses. RN-D was not clear if R24's PROM was usually completed by the NA staff or nursing. Neither RN were clear if R24's guardian or the physician were notified of the residents refusals. - At 1:17 p.m. the occupational therapist (OT)-A stated she did not write down when the Dynasplint was broken, but believed it was "approximately 1 1/2 - 2 weeks ago." OT-A stated the splint had broken "again" and they were now waiting to have it fixed. OT-A stated she offered to have the Dynasplint repaired when she heard it was broken but, "Because she [R24] wasn't on case load [at the time], I didn't record all that information." - At 1:28 p.m. OT-A stated R24 was picked up on case load on 9/18/12, for contracture management and R24's last day of occupational therapy was on 11/30/12. OT-A provided a copy of the Nursing Program (functional maintenance program, FMP) dated 11/28/12. Both the FMP and OT-A indicated the Dynasplint was to be applied twice daily for an hour each time. A second contour hand splint was to be applied two hours twice daily "as R24 tolerates." The FMP	F 157		

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F 157	Continued From page 13 directed to complete PROM of shoulder, elbow, wrist and hand before applying the splint. The care plan for physical functioning dated as revised on 7/4/11, identified R24's risk factors of TBI, hemiplegia and R24 was admitted with contracture's of bilateral lower extremities; R24 was identified to have hemiparesis and contracture of the right arm. R24 was identified as requiring total assistance with all activities of daily living, including dressing and grooming. The care plan directed to provide PROM exercises to legs and arms daily twice daily and to report changes in ROM to the nurse. The care plan directed, "Put dynamic right wrist and splint [on for] 2 hours in the morning and 2 hours in the PM [afternoon or evening]. Followed by PROM to right upper extremity. Two staff for all cares in resident room." The annual Minimum Data Set (MDS) dated 11/7/12, indicated R24 had severely impaired short and long-term memory problems, required total dependence for all activities of daily living (ADLs), and R24 was non-ambulatory. R24 was identified to have a impairment of ROM on one side of the upper extremities and both sides of the lower extremities. A Brief Interview for Mental Status was not completed due to R24's cognitive status. The Care Area Assessment (CAA) for cognition dated 11/12/12, identified R24 had impaired short and long-term memory, severely impaired decision making skills and, "Resident also has presentation of psychomotor retardation and has had behavioral symptoms of rejection of cares and physical abuse." The CAA indicated R24's diagnoses included dementia, depression, traumatic brain injury (TBI) and anxiety; R24 was "at baseline." The CAA for communication dated	F 157		

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F 157	Continued From page 14 11/12/12, indicated R24 relied on others to identify and meet her needs, indicated R24 was rarely understood and rarely able to understand. The CAA's did not address splinting or ROM. The care plan for behaviors dated as revised 4/15/13, identified physical behaviors towards staff of hitting, pinching, kicking, grabbing or pulling at others hair and R24 was "sometimes resistive to cares." The care plan did not address R24's refusal to wear the Dynasplint or PROM. The care plan did not address a second contour splint. The Quarterly MDS dated 8/7/13, indicated R24 needed extensive assistance with eating, but had not changed in ADLs or cognition from the annual MDS. The quarterly MDS indicated no changes in R24's functional ROM. The social services assessment dated 8/15/13, reviewed R24's social history prior to admission, identified R24 had the behavior of refusing cares and referred to R24's care plan. The clinical record had no further assessment of R24's refusals of cares or status of her contractures. R24's Physician Orders dated 8/29/13, directed splints to the right wrist for two hours in the morning and two hours in afternoon/evening. R24's treatment sheets from August 2013 through November 2103, indicated the following: - August - R24 did not receive PROM due to refusal, not applied due to "Other" or sleeping 18 times out of 62 opportunities. The treatment sheet indicated R24 had two Dynamic right wrist splints both applied for two hours in morning and "PM." The first splint ordered 12/4/09, was not	F 157		

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F 157	Continued From page 15 applied due to refusal or "Other" 31 times out of 62 opportunities. The second splint ordered 1/9/13, was not applied 18 out of 62 opportunities. - September - R24 did not receive PROM 11 times out of 60 opportunities; the first splint was refused or "Other" 33 times out of 60; the second splint was refused or "Other" 24 times out of 60. - October - R24 refused PROM seven times out of 62 opportunities; refused the first splint or "Other" 29 times out of 62 opportunities; the second splint was refused or "Other" 21 times out of 62 opportunities. - November - R24 did not refuse PROM; the first splint was not applied due to "Other" four times out of 12 opportunities; the second splint was not applied due to "Other" two out of 12 opportunities. Review of the clinical record indicated R24 had a consistent pattern of refusing the Dynasplint. Although the treatment sheets directed two separate splints, the clinical record did not identify the different splints. In addition, the notes regarding refusals did not include attempts to re-approach R24. The clinical record indicated R24's splint was "broken" in November and October. The clinical record lacked evidence R24's refusals were reported to the guardian or R24's physician. On 11/7/13, at 9:53 a.m. the social worker (SW)-A stated she was aware of R24's refusals to wear the splints, but was unclear when she was notified of R24's refusal to wear the splint(s), "It was some time ago." SW-A stated she read the progress notes every morning and verified R24 had no assessment of her refusals. SW-A was unclear if R24's guardian was notified of her refusals to wear the splints or allow PROM, SW-A stated any discussion with the guardian regarding risk and benefits would be completed by nursing.	F 157		

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F 157	Continued From page 16 On 11/7/13, at 10:41 a.m. the nurse practitioner (NP)-F was contacted via telephone. NP-F stated she was unaware of R24's refusals to wear the Dynasplint or contour splint and verified she was not notified the Dynasplint was broken. NP-F stated she could not recall if she was notified. NP-F stated she believed the doctor was aware of R24's condition and referred the surveyor to speak with the medical director. NP-F stated R24's condition was not expected to improve and she did "wasn't as concerned" with R24 refusing the splint. When the potential for contracture progression was explained, NP-F agreed "healthcare standards were to prevent further progression/development" of contractures. NP-F stated she was not aware of the "small details" regarding R24's condition, R24's regular assigned physician was on "maternity leave" and R24 was reassigned to the medical director until her return. On 11/7/13, at 12:31 p.m. director of nursing (DON) verified the clinical record lacked evidence the physician or guardian were notified of R24's patterns of refusal. On 11/7/13, at 1:22 p.m. R24's guardian was contacted via telephone. The guardian verified she was assigned as R24's guardian since "the beginning of the year" in February 2013 or March 2013. The guardian stated she was aware R24 refused "at times" and verified she was not notified of R24's refusal to wear the Dynasplint, or the that Dynasplint was not functional and not being worn. The guardian stated she was not informed of the risks versus benefits regarding not wearing the Dynasplint. The guardian stated she had a "good rapport" with occupational therapy and in the past was notified by therapy if	F 157		

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F 157	Continued From page 17 a resident was going to be discharged (from therapy) because of refusing to participate. The guardian explained R24 had a care conference "coming up soon" and she expected the staff to give her a detailed review of R24. The guardian stated she would be asking staff about this at the care conference and verified she expected to be notified of the refusals. On 11/7/13, a 3:07 p.m. the medical director (MD) verified he was not informed of R24's refusals to wear the Dynasplint or that the splint was broken. MD stated in an "ideal" situation he would be to notify, and would expect notification to be documented by the facility. MD stated he was a part of the physician team which rounded in the facility (residency physicians). The Notification of Change in Resident Health Status policy (undated) indicated the facility would consult the resident's physician and notify the legal representative when there was an acute illness, significant change or a life threatening condition. The policy indicated notification would be provided if there was a need to alter treatment significantly such as to "stop a form of treatment" or "commence a new form of treatment." Although the policy lacked direction to report refusals of care, the policy further directed, "Nursing judgement is an integral part of the skilled care provided...such judgement must be applied in a case by case basis in keeping with acceptable nursing practice."	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246		

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F 246	Continued From page 18 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate preferences for bathing for 2 of 2 residents (R99, R52) reviewed for choices. Findings include: R99 was admitted to the facility on 11/2/13. The Admission Record included diagnoses of bipolar disorder, mood disorder, depression, anxiety disorder and chronic pain. The Clinical Health Status dated 11/2/13, noted R99 was alert and decisions were consistent and reasonable. The immediate care plan dated 11/4/13, indicated R99 required supervision with bathing and did not include a bathing preference. When interviewed on 11/5/13, at 10:44 a.m. R99 stated a preference for baths and planned to take a bath every other day. R99 reported staff told her she could have a bath. Licensed practical nurse (LPN)-A was interviewed on 11/5/13, at 10:44 a.m. and LPN-A stated the facility had no tubs for residents to bath. A tub was observed in R99's room, but it lacked a stopper or a faucet. A tour of the facility was conducted on 11/5/13, at	F 246	F246 • R99 has been discharged from facility • R52 will be offered a tub bath as soon as tub is available. This has been explained to resident and she is in agreement. • All resident's will be asked for their bathing choices. Accommodations will be made as able except where medical condition would be endangered. • The facility has submitted the order for a bathtub on 12/10/2013. • The facility expects bathtub to be installed between 12/16/13 and 12/23/2013. • Nursing Staff will be educated on respecting resident's choices regarding bathing. • ED or designee will audit 3 residents a week for accommodation of bathing choices. • Executive Director (ED) will report audit results to QA committee. • ED is responsible. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • Completion date: December 17, 2013	

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F 246	Continued From page 19 2:17 p.m. and no operational tubs were found. R52 was admitted to the facility on 1/2/13. The Admission Record dated 1/2/13, included diagnoses of cirrhosis of the liver, alcohol dependence, chronic pain and major depressive disorder. The significant change in status Minimum Data Set (MDS) dated 2/8/13, included a Brief Interview of Mental Status (BIMS) score of 14 (cognitively intact). The MDS also noted choosing between a tub baths, showed, bed bath or sponge bath was very important. The activities of daily living (ADL) Care Area Assessment (CAA) did not address bathing preference. The facility care plan did not address bathing preferences. A medical doctor progress note dated 10/3/13, noted R52 was oriented to person, place and time but not situation. When interviewed on 11/4/13, at 4:26 p.m. R52 stated a preference to take a tub bath. R52 stated she was told a tub bath was not an option as there were no working tubs in the facility. Upon interview on 11/6/13, at 8:08 a.m. registered nurse (RN)-A reported the facility did not have a tub for residents use and if a resident requested a tub bath, it would not be an option. The director of admissions was interviewed on 11/7/13, at 10:00 a.m. and stated she was not sure if residents were told prior to admit there was no tub available in the facility. The director of admissions stated the liaison staff would answer tub questions prior to admit.	F 246		

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F 246	Continued From page 20 When interviewed on 11/7/13, at 10:06 a.m. R99 reported she was not notified the facility did not have a tub and tub baths are very important to her because of all of her medical problems. The professional marketing (liaison) person for the facility was interviewed on 1/7/13, at 10:45 a.m. and stated she doesn't talk to the residents and has never discussed if the facility had a tub or not. Upon interview on 11/7/13, at 11:15 a.m. nursing assistant (NA)-A stated sometimes residents will ask her for a tub bath but the facility did not have one so she tells the residents they can only have a shower. R52 was interviewed on 11/7/13, at 11:23 a.m. and stated taking a tub bath was very important to her but they (the facility) did not have one so " what am I supposed to do?" The administrator was interviewed on 11/7/13, at 12:51 p.m. and stated a tub was on the facility ' s maintenance plan for next year. The administrator stated the tub had not been purchased and had been on the 2013 plan but got pushed back to 2014. A policy regarding bathing preferences was requested and was not provided.	F 246		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		

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F 280	Continued From page 21 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and revise the care plan for refusals of wearing a Dynasplint (a splint that stretched joints that are lacking range of motion) for 1 of 4 residents (R24) reviewed for rehabilitation. Findings include: On 11/6/13, during observations from 7:34 a.m. through 10:18 a.m. R24 was observed to have contractures of the right elbow, wrist and hand. R24 was observed to refuse to wear a contour splint. R24 was observed to refuse PROM to the upper body. On 11/6/13, at 12:40 p.m. a registered nurse (RN)-D and the nurse manager (RN)-A both	F 280	F 280 • R24's care plan has been revised to reflect her refusals of wearing her splint. • Care plans for other Residents with history of refusing ROM/Splinting will be reviewed and updated as needed. • Care planning process has been reviewed and revised as needed. • Licensed staff will be educated on the Care Planning process and on updating care plans. • DNS/Designee will complete audit 3 care plans a week for Range of motion/splinting programs and will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS will be responsible • Completion date: December 17, 2013	

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F 280	Continued From page 22 verified if R24 refused the splint or ROM, the refusal should be reported. Both RNs stated staff should re-approach and/or try a different staff when R24 refuses. RN-D was not clear if R24's PROM was usually completed by the NA staff or nursing. The annual Minimum Data Set (MDS) dated 11/7/12, indicated R24 had severely impaired short and long-term memory problems, required total dependence for all ADLs, and R24 was non-ambulatory. R24 was identified to have a impairment of ROM on one side of the upper extremities and both sides of the lower extremities. The Care Area Assessment (CAA) for cognition dated 11/12/12, identified R24 had impaired short and long-term memory, severely impaired decision making skills and, "Resident also has presentation of psychomotor retardation and has had behavioral symptoms of rejection of cares and physical abuse." The CAA indicated R24's diagnoses included dementia, depression, traumatic brain injury (TBI) and anxiety; R24 was "at baseline." The CAA for communication dated 11/12/12, indicated R24 relied on others to identify and meet her needs, indicated R24 was rarely understood and rarely able to understand. The CAA's did not address splinting or ROM. The Quarterly MDS dated 8/7/13, indicated R24 needed extensive assistance with eating, but had not changed in ADLs or cognition from the annual MDS. The quarterly MDS indicated no changes in R24's functional ROM. The social services assessment dated 8/15/13, reviewed R24's social history prior to admission, identified R24 had the behavior of refusing cares and referred to R24's care plan.	F 280		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23 R24's Physician Orders dated 8/29/13, directed splints to the right wrist for two hours in the morning and two hours in afternoon/evening. The Admission Record dated 11/7/13, indicated R24's diagnoses included hemiplegia, anxiety disorder, depressive psychosis, dementia with behavioral disturbances, and intracranial hemorrhage. The care plan for physical functioning dated as revised on 7/4/11, identified R24's risk factors of TBI, hemiplegia and R24 was admitted with contracture's of bilateral lower extremities; R24 was identified to have hemiparesis and contracture of the right arm. R24 was identified as requiring total assistance with all activities of daily living, including dressing and grooming. The care plan directed to provide PROM exercises to legs and arms daily twice daily and to report changes in ROM to the nurse. The care plan directed, "Put dynamic right wrist and splint [on for] 2 hours in the morning and 2 hours in the PM [afternoon or evening]. Followed by PROM to right upper extremity. Two staff for all cares in resident room." - The care plan for behaviors dated as revised 4/15/13, identified physical behaviors towards staff of hitting, pinching, kicking, grabbing or pulling at others hair and R24 was "sometimes resistive to cares." The care plan did not address R24's refusal to wear the Dynasplint or PROM. The care plan did not address a second contour splint. Review of R24's IDT Progress Notes from 4/11/13, through 11/5/13, indicated the Dynasplint was "repaired" by a technician on 10/15/13. The	F 280		

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	245222	A. BUILDING _____ B. WING _____	11/07/2013

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F 280	Continued From page 24 progress notes did not address unavailability of the splint or R24's refusals to wear the splint. R24's treatment sheets indicated the following: - August - R24 did not receive PROM due to refusal, not applied due to "Other" or sleeping 18 times out of 62 opportunities. The treatment sheet indicated R24 had two Dynamic right wrist splints both applied for two hours in morning and "PM." The first splint ordered 12/4/09, was not applied due to refusal or "Other" 31 times out of 62 opportunities. The second splint ordered 1/9/13, was not applied 18 out of 62 opportunities. - September - R24 did not receive PROM 11 times out of 60 opportunities; the first splint was refused or "Other" 33 times out of 60; the second splint was refused or "Other" 24 times out of 60. - October - R24 refused PROM seven times out of 62 opportunities; refused the first splint or "Other" 29 times out of 62 opportunities; the second splint was refused or "Other" 21 times out of 62 opportunities. - November - R24 did not refuse PROM; the first splint was not applied due to "Other" four times out of 12 opportunities; the second splint was not applied due to "Other" two out of 12 opportunities. Review of the clinical record indicated R24 had a consistent pattern of refusing the Dynasplint. Although the treatment sheets directed two separate splints, the clinical record did not identify the different splints. In addition, the notes regarding refusals did not include attempts to re-approach R24. The clinical record indicated R24's splint was "broken" in November and October and lacked evidence R24's refusals were evaluated. On 11/7/13, at 9:53 a.m. the social worker (SW)-A stated she was aware of R24's refusals to wear	F 280		

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F 280	Continued From page 25 the splints, but was unclear when she was notified of R24's refusal to wear the splint(s), "It was sometime ago." SW-A stated she read the progress notes every morning and verified R24 had no evaluation of her refusals. SW-A verified she wrote the care plan for behaviors and completed the behavior CAA. SW-A verified the care plan was not revised to address R24's refusals to wear the Dynasplint or the contour splint.	F 280		
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 failed to ensure identified care plan interventions were in place to reduce falls for 1 of 3 residents (R30) reviewed for accidents. Findings include: R30 was at risk for falls according to the care plan revised on 8/3/12. The care plan implementation to minimize falls was to place a contour mattress on R30's bed. R30 ' s incident reports were reviewed from 11/1/12, going forward and the following was noted: A Minnesota Incident Report (MIR) dated 11/1/12, indicated R30 fell in room near the bed.	F 282	F 282 • R30's care plan has been revised regarding fall interventions. • All residents with falls in last 6 months care plans have been reviewed and updated as needed. • Fall intervention Care plans will be reviewed and revised if indicated on all current residents in preparation for care conference as initial, quarterly annual or change of condition MDS assessments are completed. • Facility Falls Management clinical Guideline has been reviewed and revised as needed. • Staff will be educated on updating care plans as changes occur. • DNS or designee to observe care plan for interventions for 2 residents per week for residents who have fallen in past month. • DNS will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS will be responsible. • Completion date: December 17, 2013.	

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F 282	Continued From page 26 A MIR dated 11/17/12, indicated R30 was found on the floor next to the bed with the " bed covers were cascading off side of bed to the floor. A MIR dated 2/6/13, indicated R30 was found down on knees next to the bed. A MIR dated 11/2/13, indicated R30 was found on floor near the bed. On 11/6/13, at 1:48 p.m. and 11/7/13, at 10:12 a.m. R30's bed was observed without a contour mattress on it. On 11/7/13, at 11:32 a.m. staff was observed putting a contour mattress on R30's bed. When interviewed on 11/7/13, at 11:07 a.m. the registered nurse (RN)-A unit manager verified the contour mattress was used for fall prevention and was not on R30's bed. RN-A stated she would expect identified care plan interventions would be in place. The director of nursing (DON) was interviewed on 11/7/13, at 11:37 a.m. and stated she expected identified care plan interventions to be in place for residents. A care planning policy was requested and the DON stated the facility did not have one.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 311		

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F 311	Continued From page 27 Based on observation, interview, and document review, the facility failed to provide assistance for 1 of 3 residents (R15) who were unable to independently complete nail care. Findings include: R15 was observed to have very long fingernails which were caked with black to brown substance underneath them. R15 had a quarterly Minimum Data Set (MDS), completed on 9/11/13; noted R15 had long and short term memory problems and was considered to be moderately impaired. She did display episodes of inattentiveness, had a diagnosis of dementia, disorganized thinking and psychomotor retardation. She needed extensive assistance with personal hygiene and was totally dependence with bathing. The Care Area Assessment (CAA) completed on 12/20/12, indicated R15 had impaired judgment and insight. She also had significant cognitive impairment. Her hygiene awareness was poor and she at times was resistive with cares. R15 was able to participate in all aspects of her of her personal cares and needed limited assistance of her personal hygiene. The plan of care, last revised 9/17/12, noted R15 had a physical functioning deficit related to the resident's self-care impairment. The plan directed staff to encourage resident to make choices with cares, assist with dressing and personal hygiene and assist with nail care as needed. The nursing assistant care sheet, obtained on 11/6/13, directed staff to assist R15 with her	F 311	F 311 • R15's nails were cleaned on 11/7/13, during the survey. Resident's nails will be trimmed as resident allows. Guardian informed of resident refusal on December 10, 2013. • Audit of all residents' nails will be completed to ensure they are clean and trimmed to appropriate length. • Nursing staff will be educated on providing care in accordance with the care plan. • DNS/designee to observe nail care provided on 2 residents per week to ensure they are completed in accordance with the plan of care. • DNS or designee will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS will be responsible. • Completion date: December 17, 2013	

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F 311	Continued From page 28 personal hygiene, as R15 was considered to be dependent in this area. R15 was observed on 11/4/13 at 4:13 p.m., 11/5/13 at 3:30 p.m., and 11/6/13 at 7:38 a.m. to have very long fingernails with thick brown debris under the nails. An interview on 11/6/13, at 8:44 a.m. with nursing assistant (NA)-E was completed. NA-E reported she had assisted R15 with her personal cares earlier in the day. She reported she assisted the resident to complete personal hygiene however the resident refused to have nail care completed. NA-E admitted that she was aware of "the dirt under the resident's nails." An interview on 11/7/13, at 2:11 p.m. with registered nurse (RN)-B was completed. RN-B observed R15's fingernails and verified they were very dirty and needed to be cleaned. RN-B reported the resident's nails should be cleaned whenever they were dirty. An interview with NA-C on 11/7/13, at 2:14 p.m. was completed. NA-C reported he had assisted the resident to "wash up this morning" but had not encouraged her or attempted to clean her nails. He verified the resident's nails were dirty and should be cleaned. An interview on 11/7/13, at 2:21 p.m. with RN-A was completed. RN-A verified R15's nails needed to be cleaned. An interview on 11/7/13, at 2:30 p.m. with the director of nursing (DON) was completed. She reported she expected nursing staff to ensure the nails of residents are clean. She also reported the	F 311		

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F 311	Continued From page 29 facility had no policy regarding nail care.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a decline in range of motion (ROM) was prevented for 1 of 4 residents (R24) in the sample reviewed for rehabilitation. [redacted] omitted per Gloria Deeds 12/4/2013 -RO Findings include: On 11/4/13, at 6:02 p.m. R24 was observed to be in a tilting wheelchair in her room. R24's right knee, elbow, wrist, hand and fingers were visibly contracted. R24 was not observed to be wearing a splint at the time of the observation. On 11/5/13, at 3:25 p.m. R24 was randomly observed to be in bed with no splint applied. On 11/6/13, during observations from 7:34 a.m.	F 318	F 318 • The Range of Motion plan for resident 24 has been revised to include interventions for refusals. • All residents with Range of Motion plans have been reviewed for decline in ROM. Residents with declines will be referred to therapy for evaluation and treatment. • Functional Range of Motion plans will be assessed quarterly or change of condition assessments are completed and referrals to appropriate disciplines will be made. • Facility Restorative Clinical guidelines have been reviewed. • Nursing staff will be educated on approaches and re-approaches to encourage participation in range of motion programs. • Nursing staff will also bed educated on the Restorative Clinical Guideline. • DNS or designee will observe 2 resident's range of motion cares per week for compliance with plan of care. • DNS will report results of audits to the QA committee. Continued on Page 31...	

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F 318	Continued From page 30 through 10:18 a.m. the following was observed and at no time was there a splint applied to R24'sright hand, elbow, wrist and fingers. - At 8:11 a.m. NA-F visually laid eyes on R24, and then quickly left the day room. When asked if she received range of motion to her right arm, R24 stated, "No." When asked if she did her own exercises or tried to straighten out her own arm (do own her range of motion) R24 moved her left arm and straightened it, then took the right hand and lifted it slightly. When asked if she ever wore a splint or brace on her arm, R24 shook her head, "No." - At 9:10 a.m. NA-F stated she did not assist R24 with morning cares and R24 was assisted by the night shift staff. NA-F then did approximately four to five passive range of motion (PROM) repetitions to R24's leg and knee. NA-F then attempted to provide PROM to R24's right elbow, R24 hit at NA-F with her left hand twice. NA-F redirected R24, but the resident would not allow ROM. NA-F stopped the PROM (no PROM was provided to wrist or hand). - At 9:28 a.m. NA-F stated R24 "was able to move her left (side of the body) fine." NA-F stated she usually completed five to 10 repetitions of PROM on the right upper and lower extremity. - At 9:32 a.m. after surveyor questioned if R24 had a splint, NA-F retrieved a splint from the top drawer of the bedside stand. NA-F attempted to open R24's right hand and apply the splint. R24 called out "Ow!" twice. NA-F was unable to open R24's right hand to apply the splint. R24 appeared calm, but would not allow NA-F to apply the splint by gently pushing NA-F's hands away. NA-F stated she "occasionally could not apply the splint," but stated it was usually due to R24 pushing her away. During the observation, NA-F was unable to straighten R24's right ring and	F 318	...Cont'd... • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS will be responsible. • Completion date: December 17, 2013	

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F 318	Continued From page 31 pinky finger, but was able to slightly open the rest of R24's hand. R24's hand would not form over the palm aspect of the splint. NA-F stated the refusal should be reported to the nurse and stated she would re-attempt to apply the splint. NA-F explained when R24 refused, staff was to re-approach, use different staff to re-approach and to report to the nurse was the procedure nursing assistant staff was to follow for refusals. NA-F was unclear when the splint should be applied and was unclear if R24 had more than one splint. - At 9:52 a.m. TMA-A stated she was unaware of the refusal and referred the surveyor to RN-D. RN-D was present nearby and verified no staff had approached her regarding R24's refusals of PROM or wearing a splint. No splint was applied and PROM of the upper extremity was not re-attempted for R24 during the observations. On 11/6/13, at 12:40 p.m. RN-D stated she completed the ROM on R24 prior to the observation of her completing ROM with a male resident. RN-D stated ROM was done "before [R24] got out of bed." RN-D explained the splint in the room was for the "night shift" and should be applied when R24 was in bed. RN-D stated the "Dynasplint [a splint that stretched joints that were lacking range of motion] was broken." At the time of the interview, RN-A was present and verified the Dynasplint was broken and "had been sent back to the company." RN-A stated occupational therapy was involved with sending the splint back and was aware of the Dynasplint being broken. RN-D and RN-A verified if R24 refused the splint or ROM, the refusal should be reported. Both RNs stated staff should re-approach and/or try a different staff when R24 refuses. RN-D was not clear if R24's PROM was usually completed by	F 318		

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F 318	Continued From page 32 the NA staff or nursing. - At 1:17 p.m. the occupational therapist (OT)-A stated R24 "was on case load [being seen for occupational therapy]," but not for splinting or ROM. OT-A stated she did not write down when the Dynasplint was broken, but verified she was notified and called the company to have it fixed. OT-A stated she was unclear when the Dynasplint broke, but believed it was "approximately 1 1/2 - 2 weeks ago." OT-A stated the splint had broken "again" and they were now waiting to have it fixed. OT-A stated she offered to have the Dynasplint repaired when she heard it was broken but, "Because she [R24] wasn't on case load [at the time], I didn't record all that information." OT-A verified R24 had a functional maintenance program for splinting and ROM when she "came off case load." - At 1:28 p.m. OT-A stated R24 was picked up on case load on 9/18/12, for contracture management and R24's last day of occupational therapy was on 11/30/12. OT-A provided a copy of the Nursing Program (functional maintenance program, FMP) dated 11/28/12. Both the FMP and OT-A indicated the Dynasplint was to be applied twice daily for an hour each time. A second contour hand splint was to be applied two hours twice daily "as R24 tolerates." The FMP directed to complete PROM of shoulder, elbow, wrist and hand before applying the splint. - At 1:35 p.m. OT-A verified the measurements of R24's contracture's at the end of therapy were: right elbow - 70 degrees flexion; right wrist extension contracture's with passive flexion - limited to zero degrees; right hand digits three through five demonstrated flexion contracture's at 90 degree for third digit, 60 degrees for digits four and five, second digit and thumb within functional limits. OT-A stated R24 was refusing to wear and	F 318		

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F 318	Continued From page 33 taking off the splints while she was receiving therapy and R24 would "give permission to apply [the splint], but then would take off the splint." OT-A stated R24 did not require pain medication prior to PROM or splinting. OT-A stated although the splints may have been refused, the PROM program may prevent progression of the contractures. - At 1:46 p.m. OT-A approached R24 to measure her contracture's. R24 initially agree to allow the measurement. OT-A slowly attempted to straighten R24's right arm and elbow, R24 denied pain and the contracture was measured at 95 degrees flexion. OT-A stated "that's not better." R24's wrist was measured at zero. R24 pushed OT-A away, would not answer when asked if she had pain. OT-A verified R24's elbow contracture "was getting tighter." R24 would not allow OT-A to measure the hand or finger contracture's. The care plan for physical functioning dated as revised on 7/4/11, identified R24's risk factors of TBI, hemiplegia and R24 was admitted with contracture's of bilateral lower extremities; R24 was identified to have hemiparesis and contracture of the right arm. R24 was identified as requiring total assistance with all activities of daily living, including dressing and grooming. The care plan directed to provide PROM exercises to legs and arms daily twice daily and to report changes in ROM to the nurse. The care plan directed, "Put dynamic right wrist and splint [on for] 2 hours in the morning and 2 hours in the PM [afternoon or evening]. Followed by PROM to right upper extremity. Two staff for all cares in resident room." The annual Minimum Data Set (MDS) dated 11/7/12, indicated R24 had severely impaired	F 318		

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F 318	Continued From page 34 short and long-term memory problems, required total dependence for all ADLs, and R24 was non-ambulatory. R24 was identified to have an impairment of ROM on one side of the upper extremities and both sides of the lower extremities. The Care Area Assessment (CAA) for cognition dated 11/12/12, identified R24 had impaired short and long-term memory, severely impaired decision making skills and, "Resident also has presentation of psychomotor retardation and has had behavioral symptoms of rejection of cares and physical abuse." The CAA indicated R24's diagnoses included dementia, depression, traumatic brain injury (TBI) and anxiety. The CAA indicated R24 was "at baseline." The CAA for communication dated 11/12/12, indicated R24 relied on others to identify and meet her needs, indicated R24 was rarely understood and rarely able to understand. The CAA's did not address splinting or ROM. The OT - Therapist Progress & Discharge Summary dated 3/1/13, indicated R24 was seen for wheelchair adaptations to protect her skin and prevent injury. The care plan for behaviors dated as revised 4/15/13, identified physical behaviors towards staff of hitting, pinching, kicking, grabbing or pulling at others hair and R24 was "sometimes resistive to cares." The care plan did not address R24's refusal to wear the Dynasplint or PROM. The care plan did not address a second contour splint. The Quarterly MDS dated 8/7/13, indicated R24 needed extensive assistance with eating, but had not changed in ADLs or cognition from the annual MDS. The Plan for Pain indicated R24 had no	F 318		

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F 318	Continued From page 35 visible symptoms of discomfort, that R24 offered no facial expressions or verbal protest to object to movement r/t pain or discomfort and identified R24 would show fidgeting of her hand or leg. The quarterly MDS indicated no changes in R24's functional ROM. The comprehensive Narrative Assessment dated 5/8/13, and the Quarterly Interdisciplinary Resident Review dated 8/7/13, the Pain Assessment in Advanced Dementia (PAINAD) dated 9/15/13, all indicated R24 had no pain signs or symptoms. PAINAD indicated R24 would express pain with body language only. The social services assessment dated 8/15/13, reviewed R24's social history prior to admission, identified R24 had the behavior of refusing cares and referred to R24's care plan. The clinical record had no further assessment of R24's refusals of cares or status of her contractures. The Psychiatric Progress Note dated 8/21/13, indicated R24's mood and behavior was stable and identified R24 had decreased psychomotor activity. R24's Physician Orders dated 8/29/13, directed splints to the right wrist for two hours in the morning and two hours in afternoon. Physician's Orders dated 10/28/13, indicated occupational therapy was to evaluate and treat R24. Review of R24's IDT Progress Notes from 4/11/13, through 11/5/13, indicated the Dynasplint was "repaired" by a technician on 10/15/13. The progress notes did not address unavailability of the splint or R24's refusals to wear the splint.	F 318		

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F 318	Continued From page 36 R24's treatment sheets August 2013 through November 2013 indicated the following: - August - R24 did not receive PROM due to refusal, not applied due to "Other" or sleeping 18 times out of 62 opportunities. The treatment sheet indicated R24 had two Dynamic right wrist splints both applied for two hours in morning and "PM." The first splint ordered 12/4/09, was not applied due to refusal or "Other" 31 times out of 62 opportunities. The second splint ordered 1/9/13, was not applied 18 out of 62 opportunities. - September - R24 did not receive PROM 11 times out of 60 opportunities; the first splint was refused or "Other" 33 times out of 60; the second splint was refused or "Other" 24 times out of 60. - October - R24 refused PROM seven times out of 62 opportunities; refused the first splint or "Other" 29 times out of 62 opportunities; the second splint was refused or "Other" 21 times out of 62 opportunities. - November - R24 did not refuse PROM; the first splint was not applied due to "Other" four times out of 12 opportunities; the second splint was not applied due to "Other" two out of 12 opportunities. Review of the clinical record August 2013, forward indicated R24 had a consistent pattern of refusing the Dynasplint. Although the treatment sheets directed two separate splints, the clinical record did not identify the different splints. In addition, the notes regarding refusals did not include attempts to re-approach R24. The clinical record indicated R24's splint was "broken" in November and October. Review of the undated NAR (Nursing Assistant/Registered) Assignment 3rd Floor forms (undated and printed off by RN-A at approximately 8:42 a.m. on 11/6/13), directed,	F 318		

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F 318	Continued From page 37 "NOC [night] shift to get resident dressed and leave in bed. Put Dynasplint on R [right] arm, leave on for 1 hour. PM shift to put DynaSplint R arm, leave on 1 hour. NAR report to nurse when DynaSplint is on/off." The sheet further directed, "PROM exercises to legs & arms AM/PM." The form did not address the use of another splint. On 11/7/13, at 8:42 a.m. the director of nursing (DON) was notified of a potential decline in R24's ROM. DON stated the OT-A reported the measurements of the elbow contracture to her "yesterday" and verified R24's refusals were documented in the progress notes. DON stated R24 was currently in an "assessment period," but stated there was no documentation R24's refusals were assessed prior to the current MDS assessment period. DON stated the progress notes were read by all the department heads, but was unclear if the refusals were evaluated. DON expressed she was skeptical R24's ROM had declined, as she had "cut [R24's] nails yesterday" and observed her extend her elbow "pretty straight." DON stated staff was aware of R24's refusals and stated staff should re-approach, attempt a different staff and report the refusal to the nurse. DON stated she was unclear R24 had another splint. On 11/7/13, at 9:53 a.m. the social worker (SW)-A stated she was aware of R24's refusals to wear the splints, but was unclear when she was notified of R24's refusal to wear the splint(s), "It was some time ago." SW-A stated she read the progress notes every morning and verified R24 had no assessment of her refusals. Although SW-A verified the social services department wrote the care area assessments (CAA) for behaviors and wrote the care plan for behaviors,	F 318		

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F 318	Continued From page 38 SW-A stated the nursing department was responsible for assessing resident refusals. SW-A was unclear if R24's guardian was notified of her refusals to wear the splints or allow PROM, SW-A stated any discussion with the guardian regarding risk and benefits would be completed by nursing. SW-A stated social service involvement was through participation in the interdisciplinary team (IDT) process, and the social service role was to "provide suggestions and ideas" to address behaviors (such as refusals) based on "what we know of the resident." SW-A stated she expected nursing to notify her "if resident where are higher risk [for injury or decline]" and stated she viewed R24 as "lower risk." When asked if she was aware R24's contracture could progress without splinting and ROM, SW-A explained she was unaware of any potential decline in R24's ROM. On 11/7/13, at 10:08 a.m. the DON stated there was no policy on refusals. On 11/7/13, at approximately 10:10 a.m. the OT-A stated the Dynasplint was repaired by staff at the facility. "I just wasn't strong enough to push it together, then we tightened it and now it works." On 11/7/13, at 10:41 a.m. the nurse practitioner (NP)-F was contacted via telephone. NP-F stated she was unaware of R24's refusals to wear the Dynasplint or if the Dynasplint was broken. NP-F stated she could not recall if she was notified. NP-F stated she believed the doctor was aware of R24's condition and referred the surveyor to speak with the medical director. NP-F stated R24's condition was not expected to improve and she "wasn't as concerned" with R24 refusing the splint. When the potential for contracture	F 318		

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F 318	Continued From page 39 progression was explained, NP-F agreed "healthcare standards were to prevent further progression/development" of contracture's. NP-F stated she was not aware of the "small details" regarding R24's condition, R24's regular assigned physician was on "maternity leave" and R24 was reassigned to the medical director until her return. On 11/7/13, at 11:13 a.m. the sales representative (SR) for Dynasplint was contacted via telephone. SR stated he had repaired R24's Dynasplint on "a couple of occasions" and confirmed he was notified about the Dynasplint being broken, but was unclear what was wrong. SR stated he was planning to have the splint repaired on his next visit "the first part of next week" and stated past repairs were not "anything significant" and explained repairs were usually "a screw." SR stated he was notified the splint needed to be repaired "most recently" on 10/15/13. SR verified he did not provide a replacement splint and was unclear on the protocol while the splint was out of commission. When asked about the delay in repairing the splint, SR stated he was "waiting for an authorization" for another resident in the facility to be fitted for a Dynasplint. SR explained he was planning to "group his visit" and was going to do the repair when he was up to fit the other resident. SR stated Dynasplints were fitted based off the facility's therapy assessment and the physician's order. SR explained, "I provide a wearing schedule, such as building up to tolerance, provide a picture of how it should look on the resident. I rely on the therapist." When asked if R24 did not wear the splint consistently, would R24's contracture progress, the representative stated, "I would think so." SR stated he relied upon the facility to let him know if	F 318		

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F 318	Continued From page 40 the need was more urgent and confirmed he was not informed to come sooner. SR stated he understood R24 to have "refused the splint frequently" prior to the splint requiring repair. SR stated he was unaware of facility staff repairing the R24's Dynasplint on 11/7/13. On 11/7/13, at 12:31 p.m. DON and the administrator stated there was no facility policy for care planning, assessment of behaviors, range of motion, or splinting. DON stated the facility policy for behavior assessment was to follow the RAI (resident assessment instrument) process, care planning per the RAI process and that there was some documentation in the records regarding behaviors done "on all residents" in the facility, regardless of if the resident received a psychoactive medications. DON verified the facility did not complete a root cause evaluation of behaviors. DON stated staff "look at" the clinical documentation and read the progress notes "daily." On 11/7/13, at 1:22 p.m. R24's guardian was contacted via telephone. The guardian verified she was assigned as R24's guardian since "the beginning of the year" in February or March 2013. The guardian stated she was aware R24 refused "at times" and verified she was not notified of R24's refusal to wear the Dynasplint, or the that Dynasplint was not functional and not being worn. The guardian stated she was not informed of the risks versus benefits regarding not wearing the Dynasplint. The guardian stated she had a "good rapport" with occupational therapy and in the past was notified by therapy if a resident was going to be discharged (from therapy) because of refusing to participate. The guardian explained R24 had a care conference "coming up soon" and she	F 318		

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F 318	Continued From page 41 expected the staff to give her a detailed review of R24. The guardian stated she would be asking staff about that at the care conference and verified she expected to be notified of the refusals. On 11/7/13, at 1:49 p.m. the OT-A and DON both attempted to re-measure R24's hand. After several attempts R24 continued to push staff hands away and refused measurement. R24 did not respond to questions regarding pain or discomfort and refused with non-verbal communication (pushing away) only. On 11/7/13, at 3:07 p.m. the medical director (MD) verified he was not informed of R24's refusals to wear the Dynasplint or that the splint was broken. MD stated in an "ideal" situation he expected he would be notified, and would expect notification to be documented by the facility. MD stated he was a part of the physician team which rounded in the facility (residency physicians). The resident sustained harm as the resident had a decline in ROM of the right arm contracture due to the splint not being repaired and/or applied as directed by the plan of care.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions for falls prevention were implemented for 2 of 3 residents (R15, R30) reviewed for accidents. Findings include: The facility failed to implement the interventions they had established to prevent falls for R15 and R30 who were identified a risk for falls. R15 was observed on 11/4/13, at 4:13 p.m., to be lying on her bed. A commode was in her bedroom, placed by the side of her bed. Non skid strips were observed on the floor by her bed. She was wearing " fuzzy blue slippers." R15 was observed on 11/5/13, at 3:30 p.m. walking the hall on the unit, using her walker and wearing "blue fuzzy ankle slippers" which were loose fitting and the seam in the back was torn. The slippers appeared very old and well worn. R15 was again observed on 11/6/13, at 7:38 a.m. walking the hall on the unit, using her walker and wearing "blue fuzzy slippers." The care area assessments (CAA), completed on 12/12/12, indicated R15 was often confused and forgetful and had impaired decision making skills. She displayed episodes of being inattentive and disorganized thinking. She was resistive at times with cares and wandered on the unit. She had visual and hearing impairment. The CAA identified R15 was at risk and had a history of falls. She wore appropriate footwear and clothing. It also noted her	F 323	F 323 • Resident 15 slippers were changed for shoes during survey. • A concave mattress was placed on R30's bed during survey, on 11/7/13. • All residents with falls in last 6 months will be reviewed to ensure interventions have been implemented or discontinued as appropriate. • IDT will ensure fall interventions for all residents who have fallen are in place on all current residents in preparation for care conference as initial, quarterly annual or change of condition assessments are completed. • Facility Falls Management clinical Guideline has been reviewed and revised if needed • Nursing Staff and IDT will be provided education on the Falls Management Clinical Guideline and the importance of having all fall interventions in place. • DNS or designee to observe resident and room to ensure fall prevention interventions are implemented for 2 residents/week for residents who have had a care conference that week. • DNS or designee will report results of audits to the QA committee. • Completion date: December 17, 2013	

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F 323	Continued From page 43 medication regime was not a factor for falls. The plan of care, last revised on 12/20/12, noted R15 was at risk for falls related to her history of falls, past history of falling and fractures and displaying unsafe behavior. The interventions to prevent falls included an assessment of pain, placing the call light within reach, contour mattress, educate the resident on how her actions would affect her safety, encourage R15 to wear anti-slip socks to bed, footwear to prevent slipping, keeping her environment well lit and free of clutter, observe for side effects of medication, remind her to use her walker at all times and encourage R15 to use a wheelchair when she is unsteady or weak. R15 fell on the floor on 3/5/13, at 8:00 a.m. She told staff she forgot to use her walker. As result of the fall, she was referred to occupational therapy. In addition, she was re-educated to use her walker while ambulating and removed non-stick slippers were removed and staff were to enforce the use of correct slippers. There was no indication of any injury to the resident. R15 was involved in occupational therapy (OT) from 3/6/13 to 4/5/13, to decrease the risk for falls. The discharge summary from the occupational therapist noted resident foot wear, poor walker use and bed location were contributing factors to her falls. R15 fell on 4/19/13, at 6:00 a.m. She was found on the floor at the foot of her bed and told the staff she had slid to the floor. Her commode was in front of her. She sustained a 2 centimeter (cm) skin tear and a bruise of her right hand. The post fall report indicated R15 had a history of falls, an	F 323		

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F 323	Continued From page 44 impairment of safety awareness/judgment, a recent change in roommate, was using the commode and had a hard time with change. It noted the resident was "probably" responding to bladder bowel urgency. The recommended interventions were to use a night light and night shift would assist the resident to the commode every two hours and her room was to be rearranged to reduce clutter. In addition, the call light was in reach of the resident. The resident fell on 5/7/13, at 2:15 p.m. She was heard calling from her room indistinctly and found the resident sitting on the floor next to her bed, wearing fuzzy blue slippers which were slippery on the bottom. The post fall report indicated the resident turned and slipped. It noted the underlying reason for the fall was she choice to wear inappropriate footwear. Staff obtained new well-fitting shoes and removed the "blue fuzzy slippers." They also rearranged her bed and night stand to ensure a clear path from her bed to the door of her room. On 6/20/13, at 3:10 p.m. R15 fell in her bedroom. She was found sitting between the commode and the bed. She was wearing "blue cloth slippers" on both feet. R15 reported she had slipped on the floor. Risk factors identified were R15's history of falls and impaired safety awareness and judgment. The recommended interventions included "check all shoes and assure proper non sliding shoes." In addition, non-skid strips were placed on the floor in front of the resident's commode. R15 was found on the floor by her bed on 10/12/13, at 8:15 p.m. The post fall investigation indicated R15 had lost her balance and slipped	F 323		

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F 323	Continued From page 45 while ambulating. She was wearing gripper socks and was not using her walker. No underlying conditions were identified. The causative factor was determined to be that she lost her balance and was not using her walker. The Post Fall recommendation was that call light be within reach. They also offered the resident a night light and referred the resident to physical therapy to treat for endurance. On 10/14/13, at 5:00 p.m. R15 lost her balance, slipped and fell in the dayroom due to loss of personal strength per the post fall report. She had been ambulating and was unable to inform staff of what had happened. Contributing factors were her history of falls and her impaired safety awareness/judgment. She was wear slippers and was using her walker. The recommended post fall interventions included changing the resident's footwear, ensuring environment was clear of obstacles, ensure assistive devise was within reach, use of night light. Offer fluids/food between meals and ensure bed was in the low position. R15 fell on 11/1/13, at 10:55 a.m. when she slid out of bed per her report and found on the floor. Prior to the fall, according to the post fall investigation, she was ambulating. The contributing factors included her history of falls and impaired safety awareness/judgment. She was wearing slippers and was not using any adaptive equipment at the time of the fall. The post fall report noted the resident needed assistance when transferring from her wheelchair to her bed to prevent reoccurrence. As a result of the fall, a concave mattress was obtained, staff were to check on the night light and room arrangement.	F 323		

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F 323	Continued From page 46 The quarterly Minimum Data Set (MDS) completed on 9/11/13, indicated R15 was independent with transfers and needed supervision with locomotion on and off the unit. She was unsteady moving from seated to standing but was able to stabilize herself without staff assistance. She was also unsteady moving on and off the toilets and any surface to surface transfer but again able to steady herself without staff assistance. She used a walker when she ambulated. The Nursing Assistant Care sheet obtained on 11/6/13, at 7:46 a.m. indicated R15 was dependent with all acitivties of daily living and staff were to encourage R15 to wear proper foot wear (not old slippers) when she was out of bed. An interview with registered nurse (RN)-A was completed on 11/5/13, at 2:39 p.m. She reported R15 was a fall risk and had fallen several times. She reported one of the factors was she would forget to use her walker and then would lose her balance and fall. She indicated the resident had a call light but could not remember the last time; she had used it to ask for staff assistance. She did not know if the resident could even use the call light. She also reported they had removed the "blue slippers" from the resident six times and she was always able to relocate them. She reported the slippers were very worn and the bottoms of them had no skid protection. An interview with nursing assistant (NA)-E was completed on 11/6/13, at 8:44 a.m. NA-E reported R15 had the commode by her bed to prevent falls. She indicated the resident would use an excessive amount of toilet paper and then trip and fall. She also reported R15 did not have any	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	11/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 47 other shoes, other than the blue slippers. NA-E opened the resident's closet. The closet was observed to have a three foot pile of clothing on the bottom. A beige tennis shoe was observed and NA-E dug through the clothing and found the second shoe. Upon request, R15 did allow the nursing assistant to remove the slippers and put the beige shoes on. The facility's policy, revised 2013, directed the interdisciplinary tam to evaluate the fall prevention plan of care for residents "at risk" for falls. The policy also directed licensed nurses to assess the resident after a fall and provide necessary treatment and initiate the Change in Condition Report-Post fall/Trauma. The licensed nurse is to ensure appropriate interventions are implemented and the care plan was updated. The interdisciplinary team is to review the Change of Condition Report-Post Fall and make additional recommendations within 72 hours of the fall. R30 did not have fall interventions in place as identified by the care plan. On 11/6/13, at 1:48 p.m. and 11/7/13, at 10:12 a.m. R30's bed was observed without a contour mattress on it. On 11/7/13, at 11:32 a.m. staff was observed putting a contour mattress on R30's bed. The "at risk for falls" care plan revised on 8/3/12, directed a contour mattress on R30's bed. The Comprehensive Assessment Note (CAN) dated 12/12/12, noted R30 was at risk for falls and had a history of multiple falls. The CAN also indicated R30 used a contour mattress on the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	11/07/2013

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

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F 323	Continued From page 48 bed. A Comprehensive Narrative Assessment dated 5/8/13, noted to continue same intervention to prevent falls. The Clinical Health Status assessment dated 8/7/13, noted R30 had a fall risk score of 13, which indicated at risk for falls. The Annual Minimum Data Set (MDS) dated 8/7/13, indicated R30 had diagnoses to include schizophrenia and anxiety disorder. The MDS indicated R30 had moderately impaired cognitive skills for daily decision making. R30 was noted on the MDS to have had a fall with injury since the prior assessment and required supervision and one person assist with bed mobility. The Care Area Assessment dated 8/23/13, indicated R30 was at risk for falls. A Minnesota Incident Report (MIR) dated 11/1/12, indicated R30 fell in room near the bed. - On 11/17/12, indicated R30 was found on the floor next to the bed with the "bed covers were cascading off side of bed to the floor." - On 2/6/13, indicated R30 was found down on knees next to the bed. - On 11/2/13, indicated R30 was found on floor near the bed. When interviewed on 11/7/13, at 11:07 a.m. the registered nurse (RN)-A unit manager verified the contour mattress was used for fall prevention and was not on R30's bed. RN-A stated she would expect identified care plan interventions would be in place. The director of nursing (DON) was interviewed on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	11/07/2013

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

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F 323	Continued From page 49 11/7/13, at 11:37 a.m. and stated she expected identified care plan interventions to be in place for residents. A care planning policy was requested and the DON stated the facility did not have one. The Falls Management Clinical Guidelines policy revised 2013, directed "Residents at risk for falls are care planned with individualized interventions." The Falls Risk/Post Fall Assessment Process undated, directed for residents at risk for falls, "assure any identified equipment needed is in place."	F 323		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services for 1 of 1 resident (R15) reviewed for dental services were offered.	F 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	11/07/2013

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

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F 412	Continued From page 50 Findings include: R15 was observed to have discolored broken teeth. R15 had diagnosis that included dementia. The quarterly Minimum Data Set (MDS), completed on 9/11/13; noted R15 had long and short term memory problems and was considered to be moderately cognitively impaired. She displayed episodes of inattentiveness, disorganized thinking and psychomotor retardation. She needed extensive assistance with personal hygiene and was totally dependence with bathing. The Care Area Assessment (CAA) completed on 12/20/12, indicated R15 had impaired judgment and insight. She also had significant cognitive impairment. Her hygiene awareness was poor. R15 was able to participate in all aspects of her of her personal cares and needed limited assistance of her personal hygiene. The CAA indicated R15 refused many cares and had no desire for oral cares. She had a history of refusing dental evaluations and did not allow staff to complete an oral exam other than a cursory looking into the mouth when open for talking or eating. The CAA noted there were visible broken and cracked teeth and likely carious (decayed). The assessment indicated that this would be addressed in the care plan and staff were to encourage oral hygiene and offer dental exams if the resident allowed. The plan of care, last revised 6/17/13, noted R15 had chewing difficulty related to poor dentation, at risk for dental problems related to some or all of her natural tooth loss and refused oral exams. The plan of care directed staff to assist with oral	F 412	F 412 • Resident 15 was offered dental care but refused to go to appointment . Guardian informed. • All residents will be audited for last time dental care was offered and be offered if it was not offered in the last year. • IDT will ensure all residents are offered dental services in preparation for care conference as initial, quarterly or change of condition assessments are completed. • Care conference Summary note has been updated to clearly show services were offered and accepted or refused. • DNS or designee will audit 3 Care Conference Summaries weekly. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS and ED will be responsible. • Completion date: December 17, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	11/07/2013

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

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F 412	Continued From page 51 cares as needed,educate resident on risk/benefits of refusal of oral care, inspect oral cavity for bleeding gums or other issues as allowed and refer for dental services as needed. The Nursing Assistant (NA) Care sheet, obtained on 11/6/13, directed staff to assist R15 with her personal hygiene,which would include oral hygeine, as R15 was considered to be dependent in the area. A review of the care conference summaries held 3/18/13, 6/17/13, and 9/16/13, noted a section where the resident or the representative were to be asked if they wanted a dental consultation. That was not addressed in any of the care conferences held. R15 was observed on 11/6/13, at 7:38 a.m. in the day room. She was eating breakfast independently after the staff had served her the meal. She was served a pancake, oatmeal, scrambled eggs and ground meet. She ate about 50% of the food served. An interview on 11/6/13, at 8:44 a.m. with NA-E was completed. She reported that she had assisted R15 with personal cares but the resident had refused oral cares. An interview on 11/7/13, at 2:14 p.m. with NA-C was completed. NA-C reported he had assisted the resident with personal cares but had not offered oral cares. An interview on 11/5/13, at 2:39 p.m. with registered nurse (RN)-A. She reported R15's teeth were in poor condition and was unable to determine when she was last seen by a dentist.	F 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	11/07/2013

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

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F 412	Continued From page 52 RN-A indicated that dental services are offered as care conferences but the documentation did not reflect that. She verified a dental consultation should be attempted for R15.	F 412		

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

F5222023

PRINTED: 01/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/12/2013

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

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Chateau was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

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

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

RECEIVED JAN 16 2014

RECEIVED JAN 16 2014

POC ok w/AW for KL7 1-27-14

DC: 1-21-14

EXIT: 12-13-13

RECEIVED
JAN 21 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: RYAN ONSTAD | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: 1-17-2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	12/12/2013

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter Chateau is a 4-story building, with a partial basement. The facility was constructed in 1963 and was determined to be of Type II(222) construction. The facility is fully fire sprinklered throughout. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 69 beds and had a census of 58 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	**K067** • Waiver requested. Refer to justification on form Part IV Recommendation for Waiver of Specific Life Safety Code Provisions. A W	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2013**

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

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K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include: On facility tour between 9:45 AM and 11:45 AM on 12/12/2013, observation revealed that the ventilation system has supply ducts serving the corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficient practice was verified by the administrator at the time of the inspection.	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7425

November 22, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5222023

Dear Mr. Onstad:

The above facility was surveyed on November 4, 2013 through November 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: URDS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**

2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

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

4. TYPE OF ACTION: **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 **11/07/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 5 *** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jonathan Hill, HFE NE II 12/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 2/24/14 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN-24-5222

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

Documentation supporting the facility's request for a continuing waiver involving K67 was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, January 27, 2014 1:08 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: robert.rexeisen@state.mn.us; 'Onstad, Ryan 16 [BH00871]'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Golden Livingcenter - Chateau (245222) K67 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that GLC Chateau is requesting an annual waiver for K67, corridors as a plenum. The exit date was 12-13-13.

I am recommending that CMS approve this waiver request.

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

Name of Facility

GGNSC Minneapolis Chateau dba: Golden Living Center - Chateau

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

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

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 1-27-14

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

F5222023

PRINTED: 01/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/12/2013

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

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

FIRE SAFETY

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

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Chateau was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

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

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

RECEIVED JAN 16 2014

RECEIVED JAN 16 2014

POC ok w/AW for KL7 1-27-14

DC: 1-21-14

EXIT: 12-13-13

RECEIVED
JAN 21 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: RYAN ONSTAD | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: 1-17-2014

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

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	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	12/12/2013

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter Chateau is a 4-story building, with a partial basement. The facility was constructed in 1963 and was determined to be of Type II(222) construction. The facility is fully fire sprinklered throughout. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 69 beds and had a census of 58 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	**K067** • Waiver requested. Refer to justification on form Part IV Recommendation for Waiver of Specific Life Safety Code Provisions. A W	

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	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include: On facility tour between 9:45 AM and 11:45 AM on 12/12/2013, observation revealed that the ventilation system has supply ducts serving the corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficient practice was verified by the administrator at the time of the inspection.	K 067		