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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VPDW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245270**
2.STATE VENDOR OR MEDICAID NO.
(L2) **823957600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WHITEWATER**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

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 **05/16/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 07/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/21/2014 (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
01/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/16/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245270

July 21, 2014

Ms. Dena Otto, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota 55972

Dear Ms. Otto:

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 June 30, 2014 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Bed

Your facility's Medicare approved area consists of all 55 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 16, 2014

Ms. Dena Otto, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota 55972

RE: Project Number S5270023

Dear Ms. Otto:

On May 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 16, 2014. 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 July 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 1, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 16, 2014, effective June 30, 2014 and therefore remedies outlined in our letter to you dated May 29, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

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
245270	A. Building B. Wing	7/1/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

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 **F0205** Reg. # **483.12(b)(1)&(2)** LSC	Correction Completed **06/23/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **06/23/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/23/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/23/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **06/23/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **06/23/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	07/16/2014	01060	07/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/16/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245270	01 - MAIN BUILDING 01	7/1/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	06/30/2014	ID Prefix Reg. # NFPA 101 LSC K0062	06/04/2014	ID Prefix Reg. # NFPA 101 LSC K0147	05/19/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/KFD	**Date:** 07/16/2014	**Signature of Surveyor:** 25822	**Date:** 07/01/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 5/15/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VPDW
Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245270**
2.STATE VENDOR OR MEDICAID NO.
(L2) **823957600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WHITEWATER**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

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 **05/16/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Kyla Einertson, NEII 06/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske 06/12/2014 (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
01/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 06/16/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/16/2014
(L33)

DETERMINATION APPROVAL

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

CCN-24-5270

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 the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2014

Ms. Dena Otto, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota 55972

RE: Project Number S5270023

Dear Ms. Otto:

On May 16, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-2711

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 June 23, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 16, 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 November 16, 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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 205 SS=B	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.	F 205		6/23/14

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

Electronically Signed | 06/06/2014

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
	245270	A. BUILDING _____ B. WING _____	05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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F 205	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident or legal representative written notification of the facility's bed-hold policy at the time the resident was transferred to the hospital for 4 of 4 residents (R54, R8, R4, R22) reviewed for admission, transfer and discharge. Finding Include: R54 was hospitalized and had not received the choice of a bed-hold status. Review of R54's records revealed that R54 was hospitalized on 9-14-14. The medical record lacked documentation indicating that written notification regarding the bed-hold policy was provided to the resident, resident family or legal representative. R8 was hospitalized and had not received the choice of a bed-hold status. Review of R8's records revealed that R8 was hospitalized on 12-10-13. The medical record lacked documentation indicating that written notification regarding the bed-hold policy was provided to the resident, resident family or legal representative. R4 was hospitalized and had not received the choice of a bed-hold status. Review of R4's records revealed that R4 was hospitalized on 1-22-14. The medical record lacked documentation indicating that written notification regarding the bed-hold policy was	F 205	Submission of the Response and Plan of correction is not a legal admission that a deficiency exists of that this Statement of Deficiency was correctly cited, and is also not to be construed as a admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set fort in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correct within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance. *With respect to R4, R22, R8 and R54, all residents did not receive bedholds per policy. All residents were accepted back and private pay residents were not charged days. *All residents have potential to be affected by this practice. *Upon admission, each resident receives a copy of the bedhold with an explanation and signs they understand.	

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F 205	Continued From page 2 provided to the resident, resident family or legal representative. R22 was hospitalized and had not received the choice of a bed-hold status. Review of R22's records revealed that R22 was hospitalized on 2-14-14. The medical record lacked documentation indicating that written notification regarding the bed-hold policy was provided to the resident, resident family or legal representative. During an interview on 5/15/14 at 1:11 p.m. the executive director (ED) verified when residents R54, R8, R4, and R22 were hospitalized, they had not provide the residents or legal representative written notification of the facility's bed-hold policy. The ED stated her expectation was staff would follow the facility policy and procedure to offer and obtain a bed hold for residents at the time of their hospitalization. The ED also stated she expected staff to document in the residents ' record regarding bed holds. The ED stated the wing nurse in charge of the resident or the charge nurse was to obtain the bed hold at the time of transfer, stated if the business office did not receive the bed hold, the business office was to contact the social worker to alert the social worker to obtain the bed hold. The ED verified the facility was not following the policy and procedure for bed holds. The undated facility Minnesota Notice of Bed-hold policy was reviewed and read "The notice of Bed-Hold Policy is provided to the resident/financially responsible party upon admission and at the time of leave."	F 205	*Upon discharge for hospital or therapeutic leave, the facility will provide the resident or representative with a bedhold notice. Facility will try to obtain signature at the time of discharge. *If resident or representative is unable to sign at time of discharge, facility will obtain bedhold via verbal consent over the telephone. *Residents discharged to hospital or therapeutic leave will be discussed at stand up meeting to audit if bedhold was obtained by IDT. Any missing forms will be obtained immediately verbally. *Nursing and SW educated on process. *Results of this audit will be reviewed by the QAPI team for review and any further recommendations.	

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F 247	Continued From page 3	F 247		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide notice of a room change, prior to the change occurring for 1 of 1 resident (R54) who was hospitalized at the time of the room change. Findings include: During interview on 5/12/14, at 4:13 p.m. R54 denied having received notification from the facility, prior to his room change. R54 was hospitalized from 9/20/13 to 10/16/13, according to the facilities census list. During an interview on 5/14/14 at 11:23 a.m., the executive director (ED) stated when R54 was hospitalized from 9/20/13 to 10/16/13 his room was changed. The ED verified there was no notification to the resident or his family of the room change during his hospitalization. The ED stated, "I know we are supposed to notify residents of room changes, but was unaware we needed to provide notification when a resident was in the hospital." The ED was unable to provide information or documentation on the exact date R54's room was changed during his hospitalization.	F 247	*R54 has not been discharged from facility recently nor changed rooms. He has not had another need for a relocation form, but will be notified if a future need exists. *All residents may have the potential to be affected by this practice. *Education provided by interim SW to ED, DON, and charge nurse. The practice will be using the room location form for any residents moving to another room. *The SW will review room changes monthly to monitor compliance. *Results of this audit will be reviewed by the QAPI team for review and any further recommendations.	6/23/14

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F 280	Continued From page 4	F 280		
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 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 revise the comprehensive plan of care after assessment to include appropriate treatment and services of locomotion on and off unit, toileting and transfers for 1 of 2 residents (R55) reviewed for activities of daily living and failed to revise the care plan to implement fall interventions for 2 of 3 residents (R5, R42) reviewed for accidents. Findings include:	F 280	*R55: Care plan reviewed and amended regarding locomotion, transfers, and toileting. *R5: Care plan reviewed and amended to include fall interventions recommended by IDT. *R42: Care plan reviewed and amended for fall interventions recommended by IDT.	6/23/14

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F 280	Continued From page 5 During observation on 5/14/14, at 7:23 a.m., R55 had been provided assistance by nursing assistant (NA)-A to transfer with gait belt and walker from sitting on side of bed to a standing position, transferring on/off of the toilet and transferring into wheelchair. R55 had been provided assistance by NA-A with toileting (NA-A had assisted R55 with pulling underwear and pants up). NA-A had stated cares fluctuate for R55. R55 ' s admission record dated 5/14/14, read, admitted on 12/13/12. identified diagnoses of but not limited to anxiety disorder, depression, rheumatoid arthritis, chronic airway obstruction and dementia. R55's significant change in status Minimum Data Set (MDS) dated 4/15/2014, indicated R55 brief interview of mental status (BIMS) had been 11 out of 15 on the MDS and indicated moderate cognitive impairment, required limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance) of one person physical assist for transfer, toilet use, locomotion on and off unit. R55's comprehensive care plan print date 4/28/14, identified at risk for physical functioning deficit related to mobility impairment secondary to idiopathic pulmonary fibrosis and rheumatoid arthritis. Interventions included but not limited to independent in ambulation with FWW (forward wheeled walker), toileting. R55's care plan did not address locomotion on and off unit, transfers and no further documentation on care plan for toileting. During interview on 5/14/14, at 12:40 p.m., director of nursing verified R55's care plan dated	F 280	*All residents have potential to be affected by this practice. *Facility process changed for reviewing post-fall review by IDT for immediate update of care plan. *Audits will be completed by DNS (or designee)weekly to monitor compliance. *DNS/Charge nurse will review audits monthly. Any discrepancies with new procedure will be addressed with MDS Coordinator. *Nursing staff educated on reviewing care plans daily and notifying DNS or MDS Coordinator with recommended change. *Results of this audit will be reviewed by the QAPI team for review and any further recommendations.	

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F 280	Continued From page 6 4/28/14 did not address locomotion on and off unit, transfers and toileting. Director of nursing had stated, " I would expect them to update the care plan after assessment, MDS is completed. I have no explanation for why not on care plan." During interview on 5/15/14, at 11:30 a.m., registered nurse RN-A had stated, " We have no policy for care planning." R5 had been admitted on 3/24/09 according to R5's admission record dated 5/15/14 which also identified diagnoses of but not limited to diabetes, one eye total vision impairment, glaucoma, osteoarthrosis, chronic pain, anxiety and Alzheimer ' s disease. R5 ' s significant change in status Minimum Data Set (MDS) dated 5/02/2014, indicated R5 brief interview of mental status (BIMS) had been 14 out of 15 on the MDS and indicated cognitively intact, had falls since admission or prior assessment and one with injury. Document review R5's post fall investigation/plan dated 4/19/14, identified R5 had a fall on 4/19/14, at 5:00 p.m. and IDT (interdisciplinary team) sign date 4/21/14 identified review and recommendations to be plan for resident to be in chair for meals rather than sitting at side of bed. R5's comprehensive care plan print date 3/6/14, identified at risk for falls related to history of falls. Interventions included assess for pain if fall occurs, call light and personal items available and in easy reach, encourage to call for assistance as needed, encourage to group tasks to minimize exertion with walking, gripper strips by bed and recliner, keep environment well lit and floors free of clutter, keep walker within easy reach, lipped	F 280		

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F 280	Continued From page 7	F 280		

mattress, non-skid footwear to prevent slipping and observe for side effects of medications. R5's care plan had not included recommendation for R5 to be in chair for meals rather than sitting at side of bed.

During interview on 5/15/14, at 7:44 a.m., NA-B verified caregiver guide card dated 5/12/14 had only low bed documented under fall risk/alarms/special equipment. NA-B had stated fall interventions for R5 were bed low to ground, check on R5. NA-B had stated did not know intervention in place from fall on 4/19/14 and when changes occur usually informed during nurse report in a.m. and supposed to get changed into our caregiver guide card.

During interview on 5/15/14, at 8:39 a.m., director of nursing had stated expect recommendation on 4/21/14 for R5 to be in chair for meals rather than sitting at side of bed should be on care plan. Director of nursing verified caregiver guide card dated 5/12/14 had only low bed documented under fall risk/alarms/special equipment and had stated would expect fall interventions to be on caregiver guide card for nursing assistants so aware of fall interventions for R5.

R42 had been admitted on 10/10/10 according to R42's admission record dated 4/6/13 and also identified diagnoses of but not limited to unspecified debility, anxiety, depression, mild cognitive impairment. R42 ' s quarterly Minimum Data Set (MDS) dated 4/8/2014, indicated R42 brief interview of mental status (BIMS) had been five out of 15 on the MDS and indicated severe cognitive impairment, had falls since admission or prior assessment and two with no injury.

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F 280	Continued From page 8	F 280		

Document review R42's post fall investigation/plan dated 5/8/14, identified R42 had a fall on 5/8//14, at 2:13 p.m. and recommendations/interventions taken to prevent reoccurrence had been R42 to sit in the lobby in a recliner in the afternoons after the noon meal. Tends to be the time of previous falls and R42 did not appear to be tired, was restless and wanted to get up.

R42's current comprehensive care plan print date 4/29/14, identified at risk for falls related to impaired mobility. Interventions included assess wheelchair is of appropriate size; assess need for footrests; assess need to have wheelchair locked/unlocked for safety, bed sensor alarm on when in bed to alert staff of impending transfers, chair sensor alarm on when in chair, encourage to participate in activity programming, gripper socks on bedtime and off am, keep environment well lit and floors free of clutter, assess for pain, rubber soled footwear or gripper socks to prevent slipping, observe for side effects of medications and notify physician and orientation to new room and room and roommate. R42's care plan had not included recommendation for R42 to sit in the lobby in a recliner in the afternoons after the noon meal.

During interview on 5/14/14, at 2:20 p.m., director of nursing verified post fall report intervention for fall on 5/8/14, for R42 to sit in the lobby in a recliner in the afternoons after the noon meal was not on current care plan. Director of nursing had stated would expect intervention to be communicated to staff and intervention to be put in place and on care plan and caregiver guide card to keep resident safe.

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F 280	Continued From page 9 Document review of the facility Falls Management Clinical Guidelines dated revised 2013, read "Following a resident's fall: (See Fall Decision Tree) The licensed nurse assesses the resident for injuries (including neuro checks if indicated) and provides necessary treatment and initiates the Change in Condition Report - Post Fall' Trauma. The physician and the resident's representative is notified. Appropriate interventions are implemented. (See tool: Resource for Resident Interventions to Prevent Falls attached.) Care plan is updated."	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 follow fall interventions for 1 of 3 residents (R5) reviewed for accidents and failed to ensure the comprehensive resident centered care plan was followed for toileting for 1 of 2 resident (R32) reviewed for toileting. Findings include: R5 had been admitted on 3/24/09 according to R5's admission record dated 5/15/14 and also identified diagnoses of but not limited to diabetes, one eye total vision impairment, glaucoma, osteoarthrosis, chronic pain, anxiety and Alzheimer's disease. R5's significant change in	F 282	*R5: Care plan reviewed for fall interventions by IDT. Care plan updated. *R32: Care plan reviewed by IDT and care plan updated. *All residents have potential to be affected by this practice. *Nursing staff educated on reviewing care plans daily for recommended changes - report to MDS Coordinator. *Facility process for reviewing post-fall review by IDT to allow for immediate	6/23/14

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F 282	Continued From page 10 status Minimum Data Set (MDS) dated 5/02/2014, indicated R5 brief interview of mental status (BIMS) had been 14 out of 15 on the MDS and indicated cognitively intact, had falls since admission or prior assessment and one with injury. R5's comprehensive care plan print date 3/6/14, identified at risk for falls related to history of falls. Interventions included assess for pain if fall occurs, call light and personal items available and in easy reach, encourage to call for assistance as needed, encourage to group tasks to minimize exertion with walking, gripper strips by bed and recliner, keep environment well lit and floors free of clutter, keep walker within easy reach, lipped mattress, non-skid footwear to prevent slipping and observe for side effects of medications. During observation of R5's room on 5/15/14, at 7:00 a.m., gripper strips had not been on floor by bed or recliner and R5's bed had a regular mattress on bed. During observation of R5's room on 5/15/14, at 7:44 a.m., with nursing assistant (NA)-B, NA-B verified gripper strips were not on floor by bed or recliner and R5's bed had a regular mattress on bed and not a lipped mattress. NA-B verified at the time caregiver guide card dated 5/12/14 had only low bed documented under fall risk/alarms/special equipment. NA-B had stated fall interventions for R5 were bed low to ground, check on R5. NA-B had stated when changes occur usually informed during nurse report in a.m. and supposed to get changed into our caregiver guide card. During interview on 5/15/14, at 8:39 a.m., director	F 282	update on care plans. *Audits will be completed by Charge Nurse to ensure care plans are updated post-fall for updated interventions. *DNS (or designee) will review audit results. Any discrepancies with care plans found during audits will be addressed with MDS Coordinator and other staff as appropriate. *Results of this audit will be reviewed by the QAPI team for review and any further recommendations.	

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F 282	Continued From page 11 of nursing had stated we changed the mattress on R5's bed as it appeared buckled, they must have pulled the lipped mattress out and replaced with another mattress we had in stock and did not realize it was not a lipped mattress. Director of nursing had stated in regards to gripper strips not being on floor by recliner or bed he expected assessment to be done to determine if needed anymore or apply gripper strips to floor. Director of nursing verified caregiver guide card dated 5/12/14 had only low bed documented under fall risk/alarms/special equipment and had stated would expect fall interventions to be on caregiver guide card for nursing assistants so aware of fall interventions for R5. During interview on 5/15/14, at 8:54 a.m., registered nurse (RN)-A had stated, (in regards to gripper strips on floor by bed and recliner) they were taken off floor because they had to wax the floor. During interview on 5/16/14, at 8:54 a.m., maintenance-A had stated last time R5 ' s floor had been waxed was on 8/19/13. During interview on 5/15/14, at 11:30 a.m., registered nurse RN-A had stated, " We have no policy for care planning. " F32 did not receive toileting in accordance with the plan of care. R32, as indicated on the signed physician orders dated 4/29/14, was admitted on 10/22/10 with diagnoses that included aphasia, abnormality of gait, hypoxemia, frontotemporal dementia, major depressive disorder - psychotic behaviors, anxiety state diabetes type II, delusional disorder, and chronic kidney disease as written on the physician orders signed 4/29/14.	F 282		

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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 282	Continued From page 12 The current plan of care (POC) dated 7/1/12 and revised 3/6/14 titled at risk for urinary tract infection related to history of urinary tract infections and incontinence, indicated that R32 was to have the bed pan or toileting offered upon rising, before and after meals, at bedtime and as necessary with nights to check on rounds and toilet as needed. The caregiver guide dated 5/12/14 which the nursing assistants use as a resource tool for care of the residents, indicated that R32 was a total lift for transfers, and that toileting was to be offered every 2 hours at night, upon rising, before and after meals and at bedtime. R32 was a total lift on/off the commode. On 5/15/14 at 8:57 a.m. it was observed that R32 had just finished breakfast. Two nursing assistants returned R32 to her room, used the Hoyer lift to place her on the bed, the resident was told that she was wet, and peri-care was provided. There was no offer of toileting by commode or bedpan noted. When the nursing assistant (NA) - B was asked about toileting R32, NA-B stated that they will at times offer toileting and sometimes the resident will ask for it. However, none was offered during this observation. During an interview with the nursing assistant, (NA)-F on 5/14/14 at 1:23 p.m., NA-F stated that R32 is a check, change, and reposition. R32 is fully incontinent. During an interview with the nursing assistant (NA)-E on 5/14/14 at 2:36 p.m., NA-E stated that she works on the p.m. shift. NA-E stated that she gets R32 up and she is always wet so they change her. NA-E stated that she lays R32 back down after supper and changes her. When asked if staff put her on the commode or the bedpan NA-E stated no. NA-E stated that R32	F 282		

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	245270	A. BUILDING _____ B. WING _____	05/16/2014

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F 282	Continued From page 13 does not ask to be put on the commode or bedpan. NA-E also stated she doesn ' t ask R32 if she wants to go on the commode or the bed pan. During an interview on 5/15/14 at 9:07 a.m., the Director of Nursing (DON) stated that he would expect the staff to offer toileting according to the plan of care for R32. The DON was requested to provide a care plan policy. No policy was provided.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess a change in urinary continence status for 1 of 1 resident (R40) who had a change in continence status. In addition the facility failed to complete a comprehensive bladder assessment to determine appropriate treatment and services to minimize or eliminate the resident's incontinence after the removal of an indwelling Foley catheter for 1 of 2 residents (R44) reviewed for urinary catheter use.	F 315	*R40: A bladder assessment was completed to determine toileting needs so a toileting program could be established. *R44: Resident has an indwelling catheter for chronic incontinence. He is not able to use urinal effectively nor can he reach bathroom timely due to urgency. Physician order in place for this. *All residents have the potential to be	6/23/14

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F 315	Continued From page 14 Findings Include: R40's face sheet noted R40 had been admitted on 9/8/10 with diagnoses that included but were not limited to dementia, acute but ill-defined cerebrovascular disease and hypertrophy prostate. R40's quarterly Minimum Data Set (MDS) dated 2/25/14 indicated R40 was always incontinent (this was a decline for R40) of urine, was not on a toileting program and required total dependence of two staff to toilet. The MDS assessment of 12/18/13 indicated that a toileting program was not being used to manage urinary incontinence, R40 was frequently incontinent of urine, and required extensive assist of two staff to toilet. Nurse Comprehensive review dated 3/1/14 read, "Bowel and Bladder: Rsdt [resident] is frequently incontinent of bladder ..." and on 12/20/13 read, "Bowel and Bladder: Rsdt [resident] is frequently incontinent of bladder ..." R40's most recent bladder assessment dated 9/23/13 read, "Resident is incontinent of bowel and bladder. Toilet resident upon rising, before and after meals, @ [at] HS [hour of sleep] and on rounds on night shift, check and change. Staff are to provide peri-care with am/pm cares and after each incontinent episode. Wear yellow brief." The care plan for elimination of bowel and bladder dated 9/22/10 directed staff to " toilet [R40] upon rising, after meals, at bedtime, and prn [as needed]. Rsdt [resident] wears a yellow brief for dignity and to wick urine/stool away from skin."	F 315	affected by this practice. *All residents will have bladder assesments completed following Golden Clinical Services Guidelines at admission, quarterly and when warranted by change of condition. *Charge nurse will track all residents and monitor for compliance to guidelines. *Audits will be completed weekly by DNS. *MDS Coordinator will review audit results. Any discrepancies will be addressed on 1:1 basis educating the responsible staff. *Nursing staff will be educated on the guidelines. *Results of the audits will be compiled and presented to QAPI team for review and further recommendations.	

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F 315	Continued From page 15 During an interview on 5/15/14 at 7:18 a.m., registered nurse (RN)-A stated it was rare if R40 was not incontinent of bladder and stated R40 was never dry. RN-A stated bladder assessments were completed annually, with a significant change and were reviewed quarterly for changes. During an interview on 5/15/14 at 7:33 a.m., resident nurse (RN)-A assessment coordinator verified R40 displayed a decline in incontinence according to the quarterly MDS assessment dated 2/25/14. RN-A verified the facility did not complete a bladder assessment to fully assess R40's toileting plan to prevent a permanent decline in incontinence or to maintain optimal bladder function. During an interview on 5/15/14 at 8:14 a.m. the director of nursing verified when the MDS assessment identified a concern with the change in bladder incontinence for R40 the nurse should have initiated a bowel and bladder diary for three days to establish a pattern of incontinence to make the determination of what the correct toileting program should be. The DON verified a comprehensive bladder assessment should have been done for R40 to help maintain optimal bladder function and prevent a permanent decline in bladder incontinence. R44 had Foley catheter removed on 12/5/13 and reinserted on 12/14/2013 however, a bladder assessment was not completed to determine appropriate interventions and doctor ordered treatments to assist the resident to become as incontinence free as possible. R44 had been admitted on 7/26/13. R44's quarterly Minimum Data Set (MDS) dated 1/28/14	F 315		

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F 315	Continued From page 16 identified R44's brief interview mental status (BIMS) had been 15 out of 15, cognitively intact. R44's current physician orders dated 4/8/14, identified diagnoses of but not limited to, chronic kidney disease stage three, hypertrophy prostate without urinary obstruction, retention of urine and order for indwelling Foley catheter. However, a physician ' s order dated 12/5/13, to complete a trail void in early a.m., pull catheter, re-insert catheter if no void by eight hours of removal or PRN (as needed). Document review of R44' s chart records and nursing progress notes dated 12/5/13 through 12/17/13, identified no consistent trial void in early a.m. before removing the catheter nor had any documentation done if the resident had voided before the 8 hours was up or if they had to reinsert the catheter. Document review identified R44's facility bladder assessment form and quarterly interdisciplinary resident reviews had been completed on 11/8/14 and 1/28/14 when R44 had an indwelling Foley catheter in place, however no comprehensive assessment had been completed after indwelling Foley catheter had been discontinued as ordered by physician on 12/5/13. Document review of R44 ' s nursing progress notes dated 12/5/13 through 12/17/13 identified R44 had been incontinent of bladder and had difficulty toileting and using urinal after indwelling Foley catheter had been removed, however no comprehensive bladder assessment had been completed to determine an appropriate toileting plan to eliminate or minimize the resident's incontinence after the removal of the indwelling Foley catheter. On 5/14/14, at 9:53 a.m., documentation of bladder assessment having been completed after Foley catheter had been removed after 12/5/13	F 315		

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F 315	Continued From page 17 had been requested from director of nursing. At 12:54 p.m., director of nursing stated no bladder assessment had been done after R44's catheter was pulled. At 1:58 p.m., director of nursing stated he would expect a three day void plan and bladder assessment to have been completed when R44's catheter had been removed. Document review of the facility Bladder Management (Retraining) Program dated 2006, read, "PURPOSE Retraining programs are appropriate for residents who are able to participate and have the cognitive ability to understand and follow directions/instructions. To enable the resident to control urination without catheter, if possible. To avoid the possibility of urinary tract infection. To prevent decubiti and skin irritation. To improve the morale of the resident. To restore the resident ' s dignity and respect. To restore optimum level of bladder function. PROCEDURE Without catheter: 12. Develop toileting schedule with the resident ' s participation. Toileting schedule should be as close to the resident ' s customary routine as possible. 15. Keep accurate intake and outputs. 16. Observe and record the resident ' s voiding pattern and revise toileting schedule to meet the resident ' s needs. This should be done until a routine is established. 18. If resident's customary routine is to awaken at night to urinate, plan this in the bladder management program. Awaken the resident and assist the bathroom as necessary."	F 315		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.	F 356		6/23/14

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F 356	Continued From page 18 o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the daily staffing on a daily basis. This has the potential to affect all 51 residents, staff and visitors. Findings Include: During the initial facility tour on 5/12/4 at 2:10 p.m., the daily staff posting was dated 5/11/14. During an interview on 5/12/14 at 2:43 p.m., the	F 356	*All residents have the potential to be affected by this practice. *The facility will post staffing daily indicating the actual hours worked for each category for direct care including facility name, date and resident census. *Nursing staff educated on completing the documentation accurately.	

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F 356	Continued From page 19 director of nursing verified the daily staff posting was dated 5/11/14. During an interview on 5/15/4 at 1:35 p.m., the executive director stated her expectation was every single the day the staff posting was to be posted. The ED verified the staff posting that was posted upon survey team entrance/initial tour was dated 5/11/14 and the survey team entered on 5/12/14. The ED stated the staff posting was to be completed by the night shift before they leave their shift in the morning. The ED stated there were two new nurses on the overnight shift that were working and stated the staff posting for 5/12/14 was not completed. The ED verified the facility had not followed their policy to post the staffing hours daily. The Nursing Staff Hours policy and procedure dated 3/1/13 read, "The following information shall be posted on a daily basis at the beginning of each shift ...Current Date."	F 356	*Audits will be completed by DNS (or designee)daily to ensure staff posted the sheet. Missing sheets will be addressed 1:1 educating the responsible staff. *Results of the audits will be compiled and presented to QAPI for review and further recommendation.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Living Center Whitewater 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

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

Electronically Signed | 06/06/2014

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: 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 Living Center Whitewater is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1967, with a partial basement and was determined to be of Type II(111) construction. In 1969, an addition was constructed to the West Wing that was determined to be of Type II(111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not have a corridor door that meets the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. The deficient practice could affect 10 out of 50 residents. Findings include: On facility tour between 09:30 AM and 12:30 PM on 05/15/2014, it was observed that the corridor	K 018	Submission of the Response and Plan of correction is not a legal admission that a deficiency exists of that this Statement of Deficiency was correctly cited, and is also not to be construed as a admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any	6/30/14

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K 018	Continued From page 3 double doors to the lower level beauty shop, did not have latching hardware suitable for keeping the door closed. This deficient practice was confirmed by the Facility Maintenance Director (ES) at the time of discovery.	K 018	facts alleged or the correctness of any conclusions set fort in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correct within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance. *Contractor hired and will place new hardware onto doors to make them positive latching. Parts are ordered. *Eric Schaefer, Maintenance Director, will be responsible for monitoring and correction.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 1-11.1. This deficient practice could affect all 10 out of 50 residents.	K 062	1. Missing ceiling tiles replaced in physical therapy on 5.23.14. 2. Missing ceiling tiles replaced in housekeeping closet on 6.4.14.	6/4/14

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K 062	Continued From page 4 Findings include: On facility tour between 9:30 AM and 12:30 PM on 05/15/2014, observation revealed that at the following locations there are ceiling tiles missing. This will reduce the activation time of the fire sprinkler heads. 1. Lower level - physical therapy 2. Lower level - housekeeping storage NOTE: Check the entire facility for this deficiency These deficient practices were confirmed by the Facility Maintenance Director (ES) at the time of discovery.	K 062	3. Eric Schaefer, Maintenance Director, will be responsible for monitoring and correction.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 9.1.2, 1999 NFPA 70, and 2007 Minnesota State Fire Code 605.4 and 605.5 . The deficient practice could affect 2 out of 50 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 05/15/2014, observation revealed, that the following items were found in resident room #	K 147	1. Extension cord removed at time of finding on 5.15.14. 2. Two power taps removed at time of finding on 5.15.14. 3. Resident and family education regarding allowable electrical devices took place 5.19.14. 4. Eric Schaefer, Maintenance Director, will be responsible for monitoring and	5/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/15/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE** **ST CHARLES, MN 55972**

(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 147	Continued From page 5 107: 1. One extension cord that was plugged in and then place inside beside cabinet drawer with a shaver and IPad plugged into extension cord 2. Two power taps were plugged into wall outlets on both sides of the bed. Two electrical devices were plugged into each of the power taps NOTE: Check the entire facility for this deficiency These deficient practices were confirmed by the Facility Maintenance Director (ES) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	corrections.	