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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: W06I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00182

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245541**
2.STATE VENDOR OR MEDICAID NO.
(L2) **467342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - OTTER TAIL LAKE**
(L4) **28930 COUNTY HIGHWAY 145**
(L5) **BATTLE LAKE, MN** (L6) **56515**

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

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

6. DATE OF SURVEY 03/05/2012 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (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

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	48			
(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 :
Rebecca Haberle, HFE NEII 03/28/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 05/09/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1990
(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 5/11/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/22/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN 24-5541

An extended survey was completed at this facility on 01/3/2012. At the time of the survey, conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiency was found at a S/S level of F. As a result of the survey findings, the facility would be subject to the following:

- Loss of NATCEP effective 01/03/2012 due to an extended survey and SQC.

Post Certification Revisit completed on 3/5/2012 to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B for health. Effective 02/08/2012, the facility is certified for 48 skilled nursing facility beds.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5541 May 9, 2012

Ms. Joan Gedde, Administrator
Golden Livingcenter - Otter Tail Lake
28930 County Highway 145
Battle Lake, Minnesota 56515

Dear Ms. Gedde:

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 February 28, 2012, the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900 , St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 28, 2012

Ms. Joan Gedde, Administrator
Golden Livingcenter - Otter Tail Lake
28930 County Highway 145
Battle Lake, Minnesota 56515

RE: Project Number S5541021

Dear Ms. Gedde:

On January 24, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a extended survey, completed on January 3, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 5, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 3, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 8, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 3, 2012, effective February 8, 2012 and therefore remedies outlined in our letter to you dated January 24, 2012, will not be imposed.

However, as we notified you in our letter of January 24, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 3, 2012.

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,

Pam Kerssen, Assistant Program Manager
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218)308-2129 Fax: (218)308-2122

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
245541	A. Building B. Wing	3/5/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	28930 COUNTY HIGHWAY 145 BATTLE LAKE, MN 56515

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **02/08/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/08/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/08/2012**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/08/2012**	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PK/cbl	**Date:** 03/28/2012	**Signature of Surveyor:** 18618	**Date:** 03/05/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/3/2012

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 28, 2012

Ms. Joan Gedde, Administrator
Golden Livingcenter - Otter Tail Lake
28930 County Highway 145
Battle Lake, Minnesota 56515

Re: Enclosed Reinspection Results - Project Number S5541021

Dear Ms. Gedde:

On March 5, 2012, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 3, 2012, with orders received by you on January 27, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Pam Kerssen

Pam Kerssen, Assistant Program Manager
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218)308-2129 Fax: (218)308-2122

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00182	A. Building B. Wing	3/5/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	28930 COUNTY HIGHWAY 145 BATTLE LAKE, MN 56515

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **02/08/2012**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **02/08/2012**	ID Prefix **21400** Reg. # **MN Rule 4658.0810 Subp.** LSC	Correction Completed **02/08/2012**
ID Prefix **21415** Reg. # **MN Rule 4658.0815 Subp.** LSC	Correction Completed **02/08/2012**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **02/08/2012**	ID Prefix **21915** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/08/2012**
ID Prefix **21980** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **02/08/2012**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **02/08/2012**	ID Prefix **21995** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **02/08/2012**
ID Prefix **22000** Reg. # **MN St. Statute 626.557 Su** LSC	Correction Completed **02/08/2012**	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	PK/cbl	03/28/2012	18618	03/05/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/3/2012			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W06I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00182

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245541**
2.STATE VENDOR OR MEDICAID NO.
(L2) **467342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - OTTER TAIL LAKE**
(L4) **28930 COUNTY HIGHWAY 145**
(L5) **BATTLE LAKE, MN** (L6) **56515**

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

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

6. DATE OF SURVEY **01/03/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	48			
(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 :
Rebecca Haberle, HFE NEII 02/06/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/10/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1990
(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 2/22/2012

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN 24-5541

An extended survey was completed at this facility on 01/3/2012. At the time of the survey, conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiency was found at a S/S level of F. As a result of the survey findings, the facility would be subject to the following:

- Loss of NATCEP effective 01/03/2012 due to an extended survey and SQC.

Please refer to the CMS 2567 along with the facility's plan of correction.

Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8777

January 24, 2012

Ms. Joan Gedde, Administrator
Golden Livingcenter - Otter Tail Lake
28930 County Highway 145
Battle Lake, Minnesota 56515

RE: Project Number S5541021

Dear Ms. Gedde:

On January 3, 2012, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

<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>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

DEPARTMENT CONTACT

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

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 February 12, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 12, 2012 the following remedy will be

imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Golden Livingcenter - Otter Tail Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective January 3, 2012. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 3, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 3, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Informal Dispute Requested

This facility has requested an Informal Dispute on the tag(s) identified below.

Facility (City) HFID#	Exit Date Being Disputed	Tag# - Scope/Severity Disputed
Golden LivingCenter Otter Tail Lake 00182	1-3-2012	F226=F ~~F272 =D~~ ~~F309=D~~

Larson, Monica (MDH)

From: joan.gedde@goldenliving.com
Sent: Wednesday, February 01, 2012 5:20 PM
To: *MDH_FPC-IDR
Subject: IDR Form

PROVIDER - 00182, GOLDEN LIVGCTR OTTER TAIL LAKE

IDR Type - IDR

Tags: FF226, F272, F309
Survey Date(Exit Date): 01-03-12

Review will be conducted - In writing

Dates when facility cannot participate:

Will attorney for facility be attending: No

No of persons attending:
Submitter Name: Joan Gedde
Email:joan.gedde@goldenliving.com

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 2, 2012

Ms. Joan Gedde,
Golden LivingCenter - Otter Tail Lake
28930 County Highway 145
Battle Lake, MN 56515

Dear Ms. Gedde:

This letter acknowledges receipt of your request for Informal Dispute Resolution (IDR) of the deficiencies issued at a recent Minnesota Department of Health survey of your facility.

It is my understanding that you are contesting the validity of the following:

F226 = F
F272 = D
F309 = D

I have assigned the responsibility for the IDR to Gloria Derfus . Gloria will contact you regarding the scheduling of the meeting or feel free to contact her at 651-201-3792.

Sincerely,

Mary J Absolon

Mary Absolon, Program Manager
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone : (651) 201-4100 FAX: (651) 215-9697

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Carol Moen, Assistant Program Manager
Gloria Derfus Unit Supervisor
Monica Larson

IDR 00182

MINNESOTA
MDH
DEPARTMENT of HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 7381

April 25, 2012

Ms. Joan Gedde, Administrator
Golden LivingCenter Otter Tail Lake
28930 County Highway 145
Battle Lake, Minnesota 56515

Subject: Golden LivingCenter Otter Tail Lake - IDR
CMS Certification Number (CCN): 24-5541
Project # S5541021

Dear Ms. Gedde:

This is in response to your letter of February 2, 2012, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F226, F272 and F309 issued pursuant to the survey event, WO6I11, completed on January 3, 2012.

The information presented with your letter, the CMS 2567 dated January 3, 2012, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F-226 S/S – (F) 42 CFR § 483.13 (c) Staff Treatment of Residents: The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification

agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

The basis for your IDR request for F226 was that you contend the facility has developed and is implementing policies and procedures to investigate and report allegations of abuse of residents.

The facility did not follow their policies and procedures which resulted in a potential for harm. Areas include: failed to report resident to resident allegations of abuse immediately to the administrator and to the designated state agency. The facility failed to complete a thorough internal investigation and protecting the resident during the investigation for residents in the sample who were involved in the resident to resident allegations of abuse. The facility failed to report to the designated state agency allegations of alleged staff to resident abuse.

This is a valid deficiency at this tag and at the correct scope and severity of "F".

F272 S/S – (D) 42 CFR § 483.20 Resident Assessment: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

The basis of your IDR request was that Resident 13's positioning needs were being followed as identified by the re-assessment completed by occupational therapy. Also, due to R13 having a long standing history of leaning and positioning needs. Upon review of all the documentation provided and interview with representatives of L&C, F272 is determined to not be a valid deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F 309 S/S – (D) 42 CFR section 483.25 Quality of Care: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, in accordance with the comprehensive assessment and plan of care.

The basis of your IDR request was that Resident 13's positioning needs were being followed as identified by the current plan as the plan has documented as to what works best for R13. Also, due to R13 having a long standing history of leaning and positioning needs. Upon review of all the documentation provided and interview with representatives of L&C, F309 is determined to not be a valid deficient practice under this regulation and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Facility and Provider Compliance
Telephone: 651-201-3792 Fax: 651-201-3790

cc: Office of Ombudsman for Long-Term Care
Carol Moen, Assistant Program Manager
Licensing and Certification File
Gloria Derfus, Metro C District Office Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245541	A. BUILDING _____ B. WING _____	01/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	28930 COUNTY HIGHWAY 145 BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	REVISED 4/25/2012	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and report allegations timely to the designated state authority of resident to resident suspected abuse for 3 of 3 residents (R14, R46, R29) in the sample and for suspected staff to resident abuse for 1 of 1 resident (R18) in the sample who had a potential sexual abuse incident with staff. Findings include: R14 had informed the facility on 9/19/11 of an allegation of sexual abuse and the facility had not reported it timely to the State Agency. An incident report dated 9/19/11 revealed R14 reported to a registered nurse (RN) at 4:45 p.m. a male resident yelled at her and followed her into her room. The facility licensed social worker (LSW) interviewed R14 (time and date not indicated) regarding the incident. R14 also informed the LSW of two other incidents involving	F 225		

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F 225	Continued From page 2 the same male resident, but was not sure of the dates of the incidents. R14 reported the previous week the same male resident had exposed himself to her in the south lounge at which time R14 left the room. The other incident reported by R14 that occurred approximately 3 weeks earlier was reported to the LSW. R14 stated that same male resident grabbed her arm while touching his groin and stated, " You need some sex." R14 indicated to the LSW that she feels scared as she doesn't know how strong the male resident is or what he will do. R14 also stated she felt especially unsafe once she has taken her sleeping pills because she sleeps soundly. This incident was reported to the designated State Agency (SA) at 3:30 p.m. on 9/20/11 which was 22.75 hours after the original report. The director of nursing (DON) was interviewed at 7:50 a.m. on 12/29/11. The DON indicated R14 has cognitive impairment related to her inability to care for herself and history of alcohol abuse. The DON also stated R12 has a history of urinating in garbage cans in the common areas of the facility and that R14 may have misinterpreted his actions. The DON was also interviewed at 1:00 p.m. on 12/30/11. The DON stated R14 has some dementia due to alcoholism and is very manipulative. The DON also stated there are inconsistencies in R14's stories and that anyone could be a good liar. The LSW was interviewed at 12:55 p.m. on 12/30/11. The LSW stated R14 tends to hear what she wants to hear out of a conversation, and reports that R14 will come and tell her the same stories daily, but is not aware of her making things up to get others in trouble. In addition, the	F 225		

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F 225	Continued From page 3 LSW stated that R14's cognitive level is in question since she repeats stories even though her brief interview for mental status (BIMS) was normal on 12/22/11. The LSW further indicated she was unaware of the requirement to report to the SA immediately. The LSW stated that she was informed she had 24 hours to investigate the incident prior to reporting to the SA. R46 was physically hit by R22 on 8/25/11 at 5:15 p.m. and this allegation of abuse had not been reported timely to the designated State Agency. Review of an incident report dated 8/25/11, at 5:15 p.m., R46 was seated in an office listening to music. R22 went into the office and yelled shut up to R46 several times. Staff heard yelling and went to the office and witnessed R22 grab R46 by the upper arm and hit R46 in the upper chest and the right lower lip. R46 received reddened marks on the arm, chest and lower lip. This incident was reported to the State Agency at 1:00 p.m. on 8/26/11, which was 19.75 hours after the original report. The DON was interviewed at 8:09 a.m. on 12/29/11, and confirmed the time of the incident reporting to the designated State Agency was the next day and not immediately on being notified of the allegation of abuse. R29 had reported an allegation or abuse to the facility on 9/19/11. However, the facility had not reported the allegation of abuse timely to the State Agency. Review of an incident report dated 9/19/11, revealed R29 was heard yelling in his room at	F 225		

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F 225	Continued From page 4 6:20 p.m. RN-A went into the residents room and noted R29 standing near his bed with blood on his face, hands, clothing and the floor. R29 reported the " Big guy " hit me and R29 left his room and "stomped" down the hall toward the lounge, and appeared very upset. At this time RN-A noted R50 walking down the hall toward the lounge. The LSW asked R29 to tell her what happened and he stated R50 was in his room digging in his closet. R29 told R50 to leave and when R50 didn't leave, R29 attempted to push him from the room. R29 stated R50 then hit him in the face then R50 left the room. R29 received a small abrasion of the left side of his nose, and blood was noted on the floor, and R29's face, hands and clothing. The summary of the investigative findings stated R29 alleged R50 hit him, however there were no witnesses, and it has been noted by staff R29 is not always reliable. This incident was reported to the SA at 2:30 p.m. on 9/20/11, which was 20 hours and 10 minutes after the original report. The DON was interviewed at 8:19 a.m. on 12/29/11, and stated R29 is not credible. When questioned if R29 had bleeding and was it from being hit by R50? The DON replied she had not completed the investigation, but confirmed she had reviewed the report completed by other staff, and offered no further information. At 12:05 p.m. on 12/29/11, further information was provided by the DON and administrator (ADM) The DON stated R29's injury was not serious and required no medical attention. The DON further stated the blood could be explained by R29 not making good choices, doing things to get attention, and abuse could not substantiate since R29 could have inflicted the injury upon himself.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 5 R18 had an allegation of abuse by staff. The facility was informed of the allegation of abuse on 11/3/11 however; the facility had not reported this allegation of abuse timely to the State Agency. Review of a verification of investigation form (no incident report available) dated 11/3/11, revealed that at 2:30 p.m. a nursing assistant (NA-D) reported to the LSW that on 10/27/11 (no time listed); she was assisting NA-E with R18. NA-D stated NA-E pulled R18 forward to put a lift sling under his buttocks and placed R18's head between her breasts and said to the resident, " You are right where you want to be." NA-D asked what NA-E meant and NA-E replied "right on my boobs, he likes it." The LSW interviewed R18 who did not recall the incident. The LSW also interviewed both NA's involved and NA-E denied any inappropriate behavior, but stated R18 "well he does get a little frisky with me sometimes" and will sometimes grab her chest and R18 is redirected by telling him that is inappropriate, "those are mine and you can not touch them." Both NA-D and E were re-educated on appropriate behavior and timely reporting of incidents. This possible abuse incident had not been reported to the designated State Agency. The DON was interview at 8:22 a.m. on 12/29/11. The DON confirmed she did not interview any other staff members or residents regarding inappropriate behaviors and the investigation was not broadened to include other staff members and residents due to not wanting to involve other staff in disciplinary actions concerning NA-E. The DON further stated that NA-E was re-educated on appropriate behaviors and NA-D was given a	F 225		

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F 225	Continued From page 6 verbal warning regarding timely reporting. In addition, the DON stated the re-education of both staff members was part of the investigation, and that the investigation was complete. Review of the facility policy titled Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements, dated 10/11, incorrectly directed the staff to report to the State Agency (SA) immediately (not to exceed 24 hours from the time initial knowledge that the incident occurred was received). In addition, the policy states any infliction of injury, and includes resident to resident abuse (regardless of whether serious harm occurs). In addition, any sexual contact between a facility staff person and a resident is abuse and requires the staff person to be placed on immediate leave until an investigation is completed. Based on interview and document review, the facility failed to thoroughly investigate and report allegations timely to the designated state authority of resident to resident suspected abuse for 3 of 3 residents (R14, R46, R29) in the sample and for suspected staff to resident abuse for 1 of 1 resident (R18) in the sample who had a potential sexual abuse incident with staff.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement policies and procedures to investigate and report resident to resident altercations for 3 of 4 residents (R14, R29, R46) in the sample and 1 of 1 resident (R18) in the sample with an allegation of staff to resident abuse. The failure to develop and implement vulnerable adult policies has the potential to affect all 47 residents in the facility at the time of the survey. Findings include: The facility failed to ensure the abuse/neglect policy correctly directed staff to report incidents of potential abuse immediately to the designated State Agency (SA.) Review of the facility policy titled Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements, dated 10/11, incorrectly directed the staff to report to the State Agency (SA) immediately (not to exceed 24 hours from the time initial knowledge that the incident occurred was received.) In addition, the policy states any infliction of injury, and includes resident to resident abuse (regardless of whether serious harm occurs.) In addition, any sexual contact between a facility staff person and a resident is abuse and requires the staff person to be placed	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245541	A. BUILDING _____ B. WING _____	01/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	28930 COUNTY HIGHWAY 145 BATTLE LAKE, MN 56515

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F 226	Continued From page 8 on immediate leave until an investigation is completed. R14's incident report dated 9/19/11 was reviewed and it revealed an allegation of resident to resident abuse was reported to staff at 4:45 p.m. and reported to the SA at 3:30 p.m. on 9/20/11 which was 22.75 hours after the original report. The LSW was interviewed at 12:55 p.m. on 12/30/11. LSW indicated she was unaware of the requirement to report to the SA immediately. The LSW stated that she was informed she had 24 hours to investigate the incident prior to reporting to the SA. R46's incident report date 8/25/11 was reviewed and it revealed an incident of resident to resident abuse was reported to staff at 5:15 p.m. and reported to the SA at 1:00 p.m. on 8/26/11, which was 19.75 hours after the original report. The director of nursing (DON) was interviewed at 8:09 a.m. on 12/29/11, and confirmed the time of the incident reporting to the designated State Agency was the next day (8/26/11 at 1:00 p.m.) and not immediately on being notified of the allegation of abuse. R29's incident report dated 9/19/11 was reviewed and it revealed an allegation of resident to resident abuse was reported to staff at 6:20 p.m. and reported to the SA at 2:30 p.m. on 9/20/11, which was 20 hours, 10 minutes after the original report. On 12/29/11 at 8:19 a.m. the DON was interviewed and it was learned that the DON had not completed the investigation nor had reported the incident to the administrator or designated State Agency immediately.	F 226		

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	245541	A. BUILDING _____ B. WING _____	01/03/2012

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F 226	Continued From page 9 R18's verification of investigation form (no incident report had been completed) dated 11/3/11 was reviewed and it, (no time listed) revealed an allegation of staff to resident abuse was not reported to the SA. An interview was conducted at 11:00 a.m. on 12/29/11, with the administrator (ADM) and director of nursing (DON). The policy regulations were discussed and clarified that they lacked the correct information concerning the reporting the potential abuse and or neglect to be reported immediately to the designated State Agency.	F 226		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to maintain sanitary conditions during meal services in the main dining room. This affected 8 of 44 residents (R52, R13, R2, R28, R10, R32, R45 and R36) in the home. Findings include:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 10 During the supper meal service on 12/27/11, the nursing assistants were observed to hold the residents' bread in their bare hands and buttered the bread without wash hands before handling the bread. R52 was in the dining room at 5:05 p.m. on 12/27/11. The evening meal was served in the main dining room at that time. Nursing assistant (NA)-B served R52 ' s meal. The meal consisted of sauerkraut, sausage, potatoes salad, bread and butter along with a pudding desert. NA-B removed the plate and pudding from a tray and asked R52 if he would like his bread buttered. NA-B then picked up the bread with his bare hands and used R52's knife to apply the butter. NA-B then handed the bread to R52, picked up the tray and returned to the kitchen. R13 was in the dining room on 12/27/11 at 5:08 p.m. NA-B delivered a tray to R13. NA-A again placed the plate and pudding on the table and held the bread in his bare hand while he buttered it. R2 was in the dining room on 12/27/11 at 5:11 p.m. NA-A assisted R2 with her bread. She also held the bread in her bare hand while buttering it. R28 was in the dining room on 12/27/11 at 5:11 p.m. NA-B delivered R28 his tray. NA-B again held the bread in his bare hand while buttering the bread. R10 was in the dining room on 12/27/11 at 5:14 p.m. NA-B buttered R10's bread while holding it with bare hands.	F 371		

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F 371	Continued From page 11 At 5:57 p.m. on 12/27/11 the dining room was cleared and a second group of residents entered the dining room for the evening meal. R32 was in the dining room at 6:09 p.m. on 12/27/11 and NA-B picked up R32's bread and buttered it while holding the bread with his bare hand. R45 was in the dining room at 6:18 p.m. on 12/27/11 and NA-A picked up R45's bread and buttered it with her bare hand. R36 was in the dining room at 6:18 p.m. on 12/27/11 and NA-C picked up R36's bread and held it in her bare hand and buttered it. The NA-A, B, and C were not observed to wash their hands between passing and setting up resident meal tray during the meal experience. Review of the facility policy entitled Cross-Contamination copywriter dated 2011 read: "Use spatula, tongs or single-use food grade disposable gloves when handling raw or ready to eat food." On 12/30/11 at 12:20 p.m. the certified dietary manager (CDM) and the registered dietician (RD) verified the staff should not directly touch the resident's food during service. The RD stated the staff receives education upon hire regarding how to safely butter a resident's bread without touching it. She verified the facility policy had not been followed.	F 371		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		

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F 465	Continued From page 12 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the facility in a state of good repair to promote a comfortable and sanitary environment for residents, staff and visitors. This affected 11 of 30 resident rooms (4, 5, 10, 11, 16, 20, 22, 26, 27, 30 and 31) in the facility. Findings include: The following observations were made in resident rooms on 12/27/11: Rooms 4, 5, 10, 26 and 31 contained bathroom doors that were badly scraped leaving rough and sharp edges exposed. Rooms 4, 16, 26, and 27 had missing paint around bathroom light fixtures and/or sinks. Rooms 10, 11, 20, 22, 30, 31 contained badly scraped walls with plaster exposed or large holes in walls. A facility tour was conducted at 2:20 p.m. on 12/30/11, with the maintenance manager. The maintenance manager confirmed the above findings and indicated that repairs are needed.	F 465		

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
245541	A. Building B. Wing	3/5/2012

REVISED 4/25/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	28930 COUNTY HIGHWAY 145 BATTLE LAKE, MN 56515

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 F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	Correction Completed 02/08/2012	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 02/08/2012	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 02/08/2012
ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 02/08/2012	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/3/2012

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

RECEIVED
FEB 6 2012
Minn Dept of Health
Rochester Office

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

PRINTED: 01/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245541	A. BUILDING _____ B. WING _____	01/03/2012

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of 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 forth 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 Correction 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.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	2-6-12 upn	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Hedley E.D. | TITLE: Executive Director | (X6) DATE: 02-02-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and report allegations timely to the designated state authority of resident to resident suspected abuse for 3 of 3 residents (R14, R46, R29) in the sample and for suspected staff to resident abuse for 1 of 1 resident (R18) in the sample who had a potential sexual abuse incident with staff. Findings include: R14 had informed the facility on 9/19/11 of an allegation of sexual abuse and the facility had not reported it timely to the State Agency. An incident report dated 9/19/11 revealed R14 reported to a registered nurse (RN) at 4:45 p.m. a male resident yelled at her and followed her into her room. The facility licensed social worker (LSW) interviewed R14 (time and date not indicated) regarding the incident. R14 also informed the LSW of two other incidents involving	F 225	**F 225 483.13 (c)(1)(ii)-(iii), (c)(2)- (4) Investigative/Report Allegations/Individuals** The facility does not employee individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of resident or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aid or other facility staff to the State nurse aide registry or licensing authorities. The facility does ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures (including to the state survey and certification agency).	

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F 225	Continued From page 2 the same male resident, but was not sure of the dates of the incidents. R14 reported the previous week the same male resident had exposed himself to her in the south lounge at which time R14 left the room. The other incident reported by R14 that occurred approximately 3 weeks earlier was reported to the LSW. R14 stated that same male resident grabbed her arm while touching his groin and stated, " You need some sex." R14 indicated to the LSW that she feels scared as she doesn't know how strong the male resident is or what he will do. R14 also stated she felt especially unsafe once she has taken her sleeping pills because she sleeps soundly. This incident was reported to the designated State Agency (SA) at 3:30 p.m. on 9/20/11 which was 22.75 hours after the original report. The director of nursing (DON) was interviewed at 7:50 a.m. on 12/29/11. The DON indicated R14 has cognitive impairment related to her inability to care for herself and history of alcohol abuse. The DON also stated R12 has a history of urinating in garbage cans in the common areas of the facility and that R14 may have misinterpreted his actions. The DON was also interviewed at 1:00 p.m. on 12/30/11. The DON stated R14 has some dementia due to alcoholism and is very manipulative. The DON also stated there are inconsistencies in R14's stories and that anyone could be a good liar. The LSW was interviewed at 12:55 p.m. on 12/30/11. The LSW stated R14 tends to hear what she wants to hear out of a conversation, and reports that R14 will come and tell her the same stories daily, but is not aware of her making things up to get others in trouble. In addition, the	F 225	The facility does assure that all alleged violations are thoroughly investigated, and do prevent further potential abuse while the investigation is in progress. 1. The facility has reviewed and revised the current policy as indicated. 2. All residents have the potential to be affected by the deficient practice. 3. The facility has reviewed the policy in place, and all staff have been re-educated on the policy. 4. ED or designee will review the policy annually and as needed at QA&A. Corrective action will be completed by February 08, 2012.	

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F 225	Continued From page 3 LSW stated that R14's cognitive level is in question since she repeats stories even though her brief interview for mental status (BIMS) was normal on 12/22/11. The LSW further indicated she was unaware of the requirement to report to the SA immediately. The LSW stated that she was informed she had 24 hours to investigate the incident prior to reporting to the SA. R46 was physically hit by R22 on 8/25/11 at 5:15 p.m. and this allegation of abuse had not been reported timely to the designated State Agency. Review of an incident report dated 8/25/11, at 5:15 p.m., R46 was seated in an office listening to music. R22 went into the office and yelled shut up to R46 several times. Staff heard yelling and went to the office and witnessed R22 grab R46 by the upper arm and hit R46 in the upper chest and the right lower lip. R46 received reddened marks on the arm, chest and lower lip. This incident was reported to the State Agency at 1:00 p.m. on 8/26/11, which was 19.75 hours after the original report. The DON was interviewed at 8:09 a.m. on 12/29/11, and confirmed the time of the incident reporting to the designated State Agency was the next day and not immediately on being notified of the allegation of abuse. R29 had reported an allegation or abuse to the facility on 9/19/11. However, the facility had not reported the allegation of abuse timely to the State Agency. Review of an incident report dated 9/19/11, revealed R29 was heard yelling in his room at	F 225		

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

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F 225	Continued From page 4 6:20 p.m. RN-A went into the residents room and noted R29 standing near his bed with blood on his face, hands, clothing and the floor. R29 reported the " Big guy " hit me and R29 left his room and "stomped" down the hall toward the lounge, and appeared very upset. At this time RN-A noted R50 walking down the hall toward the lounge. The LSW asked R29 to tell her what happened and he stated R50 was in his room digging in his closet. R29 told R50 to leave and when R50 didn't leave, R29 attempted to push him from the room. R29 stated R50 then hit him in the face then R50 left the room. R29 received a small abrasion of the left side of his nose, and blood was noted on the floor, and R29's face, hands and clothing. The summary of the investigative findings stated R29 alleged R50 hit him, however there were no witnesses, and it has been noted by staff R29 is not always reliable. This incident was reported to the SA at 2:30 p.m. on 9/20/11, which was 20 hours and 10 minutes after the original report. The DON was interviewed at 8:19 a.m. on 12/29/11, and stated R29 is not credible. When questioned if R29 had bleeding and was it from being hit by R50? The DON replied she had not completed the investigation, but confirmed she had reviewed the report completed by other staff, and offered no further information. At 12:05 p.m. on 12/29/11, further information was provided by the DON and administrator (ADM) The DON stated R29's injury was not serious and required no medical attention. The DON further stated the blood could be explained by R29 not making good choices, doing things to get attention, and abuse could not substantiate since R29 could have inflicted the injury upon himself.	F 225		

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F 225	Continued From page 5 R18 had an allegation of abuse by staff. The facility was informed of the allegation of abuse on 11/3/11 however; the facility had not reported this allegation of abuse timely to the State Agency. Review of a verification of investigation form (no incident report available) dated 11/3/11, revealed that at 2:30 p.m. a nursing assistant (NA-D) reported to the LSW that on 10/27/11 (no time listed); she was assisting NA-E with R18. NA-D stated NA-E pulled R18 forward to put a lift sling under his buttocks and placed R18's head between her breasts and said to the resident, " You are right where you want to be." NA-D asked what NA-E meant and NA-E replied "right on my boobs, he likes it." The LSW interviewed R18 who did not recall the incident. The LSW also interviewed both NA's involved and NA-E denied any inappropriate behavior, but stated R18 "well he does get a little frisky with me sometimes" and will sometimes grab her chest and R18 is redirected by telling him that is inappropriate, "those are mine and you can not touch them." Both NA-D and E were re-educated on appropriate behavior and timely reporting of incidents. This possible abuse incident had not been reported to the designated State Agency. The DON was interview at 8:22 a.m. on 12/29/11. The DON confirmed she did not interview any other staff members or residents regarding inappropriate behaviors and the investigation was not broadened to include other staff members and residents due to not wanting to involve other staff in disciplinary actions concerning NA-E. The DON further stated that NA-E was re-educated on appropriate behaviors and NA-D was given a	F 225		

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F 225	Continued From page 6 verbal warning regarding timely reporting. In addition, the DON stated the re-education of both staff members was part of the investigation, and that the investigation was complete. Review of the facility policy titled Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements, dated 10/11, incorrectly directed the staff to report to the State Agency (SA) immediately (not to exceed 24 hours from the time initial knowledge that the incident occurred was received). In addition, the policy states any infliction of injury, and includes resident to resident abuse (regardless of whether serious harm occurs). In addition, any sexual contact between a facility staff person and a resident is abuse and requires the staff person to be placed on immediate leave until an investigation is completed. Based on interview and document review, the facility failed to thoroughly investigate and report allegations timely to the designated state authority of resident to resident suspected abuse for 3 of 3 residents (R14, R46, R29) in the sample and for suspected staff to resident abuse for 1 of 1 resident (R18) in the sample who had a potential sexual abuse incident with staff.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement policies and procedures to investigate and report resident to resident altercations for 3 of 4 residents (R14, R29, R46) in the sample and 1 of 1 resident (R18) in the sample with an allegation of staff to resident abuse. The failure to develop and implement vulnerable adult policies has the potential to affect all 47 residents in the facility at the time of the survey. Findings include: The facility failed to ensure the abuse/neglect policy correctly directed staff to report incidents of potential abuse immediately to the designated State Agency (SA.) Review of the facility policy titled Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements, dated 10/11, incorrectly directed the staff to report to the State Agency (SA) immediately (not to exceed 24 hours from the time initial knowledge that the incident occurred was received.) In addition, the policy states any infliction of injury, and includes resident to resident abuse (regardless of whether serious harm occurs.) In addition, any sexual contact between a facility staff person and a resident is abuse and requires the staff person to be placed	F 226	**F 226 483.13(c) Development/implement Abuse/Neglect, ETC Policies** The facility has developed and implemented written policies and procedures that prohibits mistreatment, neglect, and abuse of resident and misappropriation of resident property. The facility does assure that all alleged violations are thoroughly investigated, and do prevent further potential abuse while the investigation is in progress. 1. The facility has reviewed and revised the current policy as indicated. 2. All residents have the potential to be affected by the deficient practice. 3. The facility has reviewed the policy in place, and all staff have been re-educated on the policy. 4. ED or designee will review the policy annually and as needed at QA&A. Corrective action will be completed by February 08, 2012.	

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F 226	Continued From page 8 on immediate leave until an investigation is completed. R14's incident report dated 9/19/11 was reviewed and it revealed an allegation of resident to resident abuse was reported to staff at 4:45 p.m. and reported to the SA at 3:30 p.m. on 9/20/11 which was 22.75 hours after the original report. The LSW was interviewed at 12:55 p.m. on 12/30/11. LSW indicated she was unaware of the requirement to report to the SA immediately. The LSW stated that she was informed she had 24 hours to investigate the incident prior to reporting to the SA. R46's incident report date 8/25/11 was reviewed and it revealed an incident of resident to resident abuse was reported to staff at 5:15 p.m. and reported to the SA at 1:00 p.m. on 8/26/11, which was 19.75 hours after the original report. The director of nursing (DON) was interviewed at 8:09 a.m. on 12/29/11, and confirmed the time of the incident reporting to the designated State Agency was the next day (8/26/11 at 1:00 p.m.) and not immediately on being notified of the allegation of abuse. R29's incident report dated 9/19/11 was reviewed and it revealed an allegation of resident to resident abuse was reported to staff at 6:20 p.m. and reported to the SA at 2:30 p.m. on 9/20/11, which was 20 hours, 10 minutes after the original report. On 12/29/11 at 8:19 a.m. the DON was interviewed and it was learned that the DON had not completed the investigation nor had reported the incident to the administrator or designated State Agency immediately.	F 226		

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F 226	Continued From page 9 R18's verification of investigation form (no incident report had been completed) dated 11/3/11 was reviewed and it, (no time listed) revealed an allegation of staff to resident abuse was not reported to the SA. An interview was conducted at 11:00 a.m. on 12/29/11, with the administrator (ADM) and director of nursing (DON). The policy regulations were discussed and clarified that they lacked the correct information concerning the reporting the potential abuse and or neglect to be reported immediately to the designated State Agency.	F 226		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	**F 272 483.20(b)(1) Comprehensive Assessments** The facility does conduct initial and periodic comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 1. R13 has had a comprehensive assessment for positioning on an ongoing basis. R13's positioning was reviewed and is current for his seating and positioning needs as recommended by OT 2. All residents in wheel chairs have the potential to be affected by the deficient practice. All residents will be reviewed for wheel chair positioning needs. 3. All residents will continue to be assessed for positioning needs during quarterly assessments, and as needed screens will be sent to OT for positioning needs. 4. DNS or designee will do weekly audits of resident positioning to assure compliance. Outcomes will be reviewed at QA&A. Corrective action will be completed by February 08, 2012.	

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F 272	Continued From page 10 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess body positioning for 1 of 2 residents (R13) in the sample whose head was leaning to the right and resting on the wheel chair frame. Findings include: R13 did not have a comprehensive assessment for positioning and was noted to lean to the right and rest his head against the metal handle of the wheelchair. Diagnoses for R13 included, multiple sclerosis, dementia, psychosis and depression. The annual Minimum Data set (MDS) dated 12/29/2011 identified R13 to have cognitive impairment with no acute onset of mental status changes, and to need extensive assistance with all activities of daily living (ADLs), except for eating, which	F 272		

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F 272	Continued From page 11 required set up and queuing. The assessment lacked an assessment for the head leaning to the right nor interventions to promote good body alignment. At 8:20 a.m. on 12/28/11, R13 was observed in the dining room, leaning to the side with his head resting on a metal bar that appeared to be an extension of the handle of the wheelchair. When questioned, R13 stated it was not comfortable. At 2:30 p.m. on 12/29/11, R13 was observed with his head resting against the bar which was covered with a washcloth taped around the bar. At 9:40 a.m. on 12/30/11, R13 was observed in his room with his head leaning on the metal bar, which again had a washcloth loosely taped over it. The director of nursing (DON) was interviewed at 11:03 a.m. on 12/29/11. The DON stated she was unaware of R13 resting his head on the metal bar, and that she has noted R13 leaning to the right side and has asked R13 to sit up and R13 is able to do so. The DON also stated that much work has been done with the Veteran's Administration (VA) hospital in Fargo regarding wheelchairs, neck braces, and head rests, and she would provide documentation. The DON was informed of the lack of a comprehensive assessment on the quarterly MDS completed on 10/13/11.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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F 309	Continued From page 12 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the proper positioning to promote comfort for 1 of 2 residents (R13) in the sample who was reviewed for positioning. Findings include: R13 did not have a comprehensive assessment for positioning and was noted to lean to the right and rest his head against the metal handle of the wheelchair. Diagnoses for R13 included, multiple sclerosis, dementia, psychosis and depression. The quarterly Minimum Data Set (MDS) dated 10/13/11, identified R13 to have cognitive impairment with no acute onset of mental status changes, and to need extensive assistance with all activities of daily living (ADLs), except for eating, which requires set up and queuing. The plan of care dated 4/27/10, indicated limited to extensive assistance needed for all ADLs, and R13 is unable to reliably notify staff of needs and staff are to anticipate needs. The plan of care did not address the lack of a head rest on R13's wheelchair. At 8:20 a.m. on 12/28/11, R13 was observed in the dining room, leaning to the side with his head resting on a metal bar that appeared to be an	F 309	**F 309 483.25 Provide Care/Services for Highest well being.** Each resident does receive, and the facility does provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. R13 has had a comprehensive assessment for positioning on an ongoing basis. R13's positioning was reviewed and is current for his seating and positioning needs as recommended by OT 2. All residents in wheel chairs have the potential to be affected by the deficient practice. All residents will be reviewed for wheel chair positioning needs. 3. All residents will continue to be assessed for positioning needs during quarterly assessments, and as needed screens will be sent to OT for positioning needs. 4. DNS or designee will do weekly audits of resident positioning to assure compliance. Outcomes will be reviewed at QA&A. Corrective action will be completed by February 08, 2012.	

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F 309	Continued From page 13 extension of the handle of the wheelchair. When questioned, R13 stated it was not comfortable. At 2:30 p.m. on 12/29/11, R13 was observed with his head resting against the bar which was covered with a washcloth taped around the bar. At 9:40 a.m. on 12/30/11, R13 was observed in his room with his head leaning on the metal bar, which again had a washcloth loosely taped over it. At 8:57 a.m. on 1/3/12, R13 was observed in the dining room with his head resting against the wheelchair handle which was covered with foam padding. This was after the facility was informed of the concern with R13's head positioning. The director of nursing (DON) was interviewed at 11:03 a.m. on 12/29/11. The DON stated she was unaware of R13 resting his head on the metal bar, and that she has noted R13 leaning to the right side and has asked R13 to sit up and R13 is able to do so. The DON also stated that much work has been done with the Veteran's Administration (VA) hospital in Fargo, North Dakota regarding wheelchairs, neck braces, and head rests, and she would provide documentation. At 3:45 p.m. on 12/29/11, R13's family member (FM)-1 asked to speak to the surveyor. The FM indicated the VA hospital had given R13 a special headrest to be placed on the wheelchair, and she had inquired the staff several times why the headrest is not used. In addition, the FM stated she had pointed out to several staff indents in R13's head where he has rested it against the bar, and she had made the padding with the washcloth that is now being used. The FM also	F 309		

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F 309	Continued From page 14 stated the staff have informed her that the headrest has not worked and do not know where to locate it. An interview with the DON was conducted at 1:15 p.m. at 12/30/11. The DON stated R13 is no longer in the chair furnished to him by the VA and he had refused to use the headrest with a strap. The DON also stated she knows the FM wants what is best for the resident, but is unrealistic in what he will allow the staff to do. Documents from the VA hospital were reviewed and indicated several communications occurred between the facility and the VA hospital in 2007 and 2008. The records indicated 9 visits to the occupational department (OT) for proper wheelchair fitting and positioning. The most recent document dated 3/19/08, indicated a new wheelchair had been fitted for R13, and no further documentation was provided.	F 309		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, document review and	F 371		

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F 371	Continued From page 15 staff interview, the facility failed to maintain sanitary conditions during meal services in the main dining room. This affected 8 of 44 residents (R52, R13, R2, R28, R10, R32, R45 and R36) in the home. Findings include: During the supper meal service on 12/27/11, the nursing assistants were observed to hold the residents' bread in their bare hands and buttered the bread without wash hands before handling the bread. R52 was in the dining room at 5:05 p.m. on 12/27/11. The evening meal was served in the main dining room at that time. Nursing assistant (NA)-B served R52 ' s meal. The meal consisted of sauerkraut, sausage, potatoes salad, bread and butter along with a pudding desert. NA-B removed the plate and pudding from a tray and asked R52 if he would like his bread buttered. NA-B then picked up the bread with his bare hands and used R52's knife to apply the butter. NA-B then handed the bread to R52, picked up the tray and returned to the kitchen. R13 was in the dining room on 12/27/11 at 5:08 p.m. NA-B delivered a tray to R13. NA-A again placed the plate and pudding on the table and held the bread in his bare hand while he buttered it. R2 was in the dining room on 12/27/11 at 5:11 p.m. NA-A assisted R2 with her bread. She also held the bread in her bare hand while buttering it. R28 was in the dining room on 12/27/11 at 5:11	F 371	**F 371 483.35(i) Food procure, Store/ Prepare/Serve-Sanitary** The facility does: (1) procure food from sources approved or considered satisfactory by Federal, Sate or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. 1. All nursing assistant have been re-educated that they can not hold and butter bread with their bare hands. 2. All residents have the potential to be affected by the deficient practice. All nursing assistants have been re-educated maintaining sanitary conditions during meals service. 3. All nursing assistants will be re-educated on maintaining sanitary conditions during meal service. 4. DNS or designee will do weekly audits to assure that staff are maintaining sanitary conditions during meals service. Audits will be reviewed through the monthly QA&A Committee. Corrective action will be completed by February 08, 2012.	

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F 371	Continued From page 16 p.m. NA-B delivered R28 his tray. NA-B again held the bread in his bare hand while buttering the bread. R10 was in the dining room on 12/27/11 at 5:14 p.m. NA-B buttered R10's bread while holding it with bare hands. At 5:57 p.m. on 12/27/11 the dining room was cleared and a second group of residents entered the dining room for the evening meal. R32 was in the dining room at 6:09 p.m. on 12/27/11 and NA-B picked up R32's bread and buttered it while holding the bread with his bare hand. R45 was in the dining room at 6:18 p.m. on 12/27/11 and NA-A picked up R45's bread and buttered it with her bare hand. R36 was in the dining room at 6:18 p.m. on 12/27/11 and NA-C picked up R36's bread and held it in her bare hand and buttered it. The NA-A, B, and C were not observed to wash their hands between passing and setting up resident meal tray during the meal experience. Review of the facility policy entitled Cross-Contamination copywriter dated 2011 read: "Use spatula, tongs or single-use food grade disposable gloves when handling raw or ready to eat food." On 12/30/11 at 12:20 p.m. the certified dietary manager (CDM) and the registered dietician (RD) verified the staff should not directly touch the	F 371		

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F 371	Continued From page 17 resident's food during service. The RD stated the staff receives education upon hire regarding how to safely butter a resident's bread without touching it. She verified the facility policy had not been followed.	F 371		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the facility in a state of good repair to promote a comfortable and sanitary environment for residents, staff and visitors. This affected 11 of 30 resident rooms (4, 5, 10, 11, 16, 20, 22, 26, 27, 30 and 31) in the facility. Findings include: The following observations were made in resident rooms on 12/27/11: Rooms 4, 5, 10, 26 and 31 contained bathroom doors that were badly scraped leaving rough and sharp edges exposed. Rooms 4, 16, 26, and 27 had missing paint around bathroom light fixtures and/or sinks. Rooms 10, 11, 20, 22, 30, 31 contained badly scraped walls with plaster exposed or large holes in walls. A facility tour was conducted at 2:20 p.m. on 12/30/11, with the maintenance manager. The maintenance manager confirmed the above	F 465	**F 465 Safe/Functional/sanitary/Comfortable Environment** The facility does provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. Rooms 4,5,10,11,16,20,22,26,27,30,and 31 have had maintenance repairs and promote a comfortable and sanitary environment for residents, staff, and visitors. 2. All residents have the potential to be affected by the deficient practice. The Maintenance Supervisor will check resident room conditions on a weekly basis with his environmental audits. 3. Any environmental repairs needed will be documented and presented to Executive Director. The Executive director will do monthly reviews of all residents rooms. 4. The Executive Director and Director of Environmental Services remain responsible for this requirement to ensure the facility is safe, functional, sanitary, and comfortable for residents, staff, and the public. The Maintenance Director will bring any concerns identified during the audits to the monthly QA&A Committee. Corrective action will be completed by February 08, 2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245541	A. BUILDING _____ B. WING _____	01/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	28930 COUNTY HIGHWAY 145 BATTLE LAKE, MN 56515

(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 465	Continued From page 18 findings and indicated that repairs are needed.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245541	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/28/2011**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	**28930 COUNTY HIGHWAY 145** **BATTLE LAKE, MN 56515**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Otter Tail Lake was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Golden Livingcenter Otter Tail Lake was building in 2 stages. The main building was built in 1968 is a 1-story building without a basement and was determined to be Type II (111) construction. A physical therapy addition was constructed to the south of the original building, is 1-story, without a basement, and was determined to be Type II (000) construction. It is separated with 2 hour fire rated construction. The facility has 3 smoke zones divided by 30 minute fire barriers. The building is fully sprinkler protected with a wet pipe sprinkler system with standard response heads in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes smoke detection at the smoke barrier doors and in areas open to the corridor system installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). All hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code (2007 edition). The fire alarm system has automatic fire department notification	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245541	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/28/2011**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	**28930 COUNTY HIGHWAY 145** **BATTLE LAKE, MN 56515**

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K 000	Continued From page 1 The facility has a capacity of 56 beds and had a census of 47 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8777

January 24, 2012

Ms. Joan Gedde, Administrator
Golden Livingcenter - Otter Tail Lake
28930 County Highway 145
Battle Lake, Minnesota 56515

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5541021

Dear Ms. Gedde:

The above facility was surveyed on December 27, 2011 through January 3, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Gary Nederhoff, Unit Supervisor, 18 Wood Lake Drive Southeast, Rochester, Minnesota 55904. 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,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00182	A. BUILDING _____ B. WING _____	01/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	28930 COUNTY HIGHWAY 145 BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 27, 28, 29, 30, 2011 and January 3, 2012 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000		

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the proper positioning to promote comfort for 1 of 2 residents (R13) in the sample who was reviewed for positioning. Findings include: R13 did not have a comprehensive assessment for positioning and was noted to lean to the right and rest his head against the metal handle of the wheelchair. Diagnoses for R13 included, multiple sclerosis, dementia, psychosis and depression. The quarterly Minimum Data Set (MDS) dated	2 830		

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2 830	Continued From page 2 10/13/11, identified R13 to have cognitive impairment with no acute onset of mental status changes, and to need extensive assistance with all activities of daily living (ADLs), except for eating, which requires set up and queuing. The plan of care dated 4/27/10, indicated limited to extensive assistance needed for all ADLs, and R13 is unable to reliably notify staff of needs and staff are to anticipate needs. The plan of care did not address the lack of a head rest on R13's wheelchair. At 8:20 a.m. on 12/28/11, R13 was observed in the dining room, leaning to the side with his head resting on a metal bar that appeared to be an extension of the handle of the wheelchair. When questioned, R13 stated it was not comfortable. At 2:30 p.m. on 12/29/11, R13 was observed with his head resting against the bar which was covered with a washcloth taped around the bar. At 9:40 a.m. on 12/30/11, R13 was observed in his room with his head leaning on the metal bar, which again had a washcloth loosely taped over it. At 8:57 a.m. on 1/3/12, R13 was observed in the dining room with his head resting against the wheelchair handle which was covered with foam padding. This was after the facility was informed of the concern with R13's head positioning. The director of nursing (DON) was interviewed at 11:03 a.m. on 12/29/11. The DON stated she was unaware of R13 resting his head on the metal bar, and that she has noted R13 leaning to the right side and has asked R13 to sit up and R13 is able to do so. The DON also stated that much work has been done with the Veteran's Administration (VA) hospital in Fargo, North Dakota regarding wheelchairs, neck braces, and	2 830		

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2 830	Continued From page 3 head rests, and she would provide documentation. At 3:45 p.m. on 12/29/11, R13's family member (FM)-1 asked to speak to the surveyor. The FM indicated the VA hospital had given R13 a special headrest to be placed on the wheelchair, and she had inquired the staff several times why the headrest is not used. In addition, the FM stated she had pointed out to several staff indents in R13's head where he has rested it against the bar, and she had made the padding with the washcloth that is now being used. The FM also stated the staff have informed her that the headrest has not worked and do not know where to locate it. An interview with the DON was conducted at 1:15 p.m. at 12/30/11. The DON stated R13 is no longer in the chair furnished to him by the VA and he had refused to use the headrest with a strap. The DON also stated she knows the FM wants what is best for the resident, but is unrealistic in what he will allow the staff to do. Documents from the VA hospital were reviewed and indicated several communications occurred between the facility and the VA hospital in 2007 and 2008. The records indicated 9 visits to the occupational department (OT) for proper wheelchair fitting and positioning. The most recent document dated 3/19/08, indicated a new wheelchair had been fitted for R13, and no further documentation was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all residents are properly positioned. The director of nursing or her	2 830		

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2 830	Continued From page 4 designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to maintain sanitary conditions during meal services in the main dining room. This affected 8 of 44 residents (R52, R13, R2, R28, R10, R32, R45 and R36) in the home. Findings include: During the supper meal service on 12/27/11, the nursing assistants were observed to hold the residents' bread in their bare hands and buttered the bread without wash hands before handling the bread. R52 was in the dining room at 5:05 p.m. on 12/27/11. The evening meal was served in the main dining room at that time. Nursing assistant (NA)-B served R52 ' s meal. The meal consisted of sauerkraut, sausage, potatoes salad, bread and butter along with a pudding desert. NA-B removed the plate and pudding from a tray and asked R52 if he would like his bread buttered. NA-B then picked up the bread with his bare	21015		

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21015	Continued From page 5 hands and used R52's knife to apply the butter. NA-B then handed the bread to R52, picked up the tray and returned to the kitchen. R13 was in the dining room on 12/27/11 at 5:08 p.m. NA-B delivered a tray to R13. NA-A again placed the plate and pudding on the table and held the bread in his bare hand while he buttered it. R2 was in the dining room on 12/27/11 at 5:11 p.m. NA-A assisted R2 with her bread. She also held the bread in her bare hand while buttering it. R28 was in the dining room on 12/27/11 at 5:11 p.m. NA-B delivered R28 his tray. NA-B again held the bread in his bare hand while buttering the bread. R10 was in the dining room on 12/27/11 at 5:14 p.m. NA-B buttered R10's bread while holding it with bare hands. At 5:57 p.m. on 12/27/11 the dining room was cleared and a second group of residents entered the dining room for the evening meal. R32 was in the dining room at 6:09 p.m. on 12/27/11 and NA-B picked up R32's bread and buttered it while holding the bread with his bare hand. R45 was in the dining room at 6:18 p.m. on 12/27/11 and NA-A picked up R45's bread and buttered it with her bare hand. R36 was in the dining room at 6:18 p.m. on 12/27/11 and NA-C picked up R36's bread and held it in her bare hand and buttered it.	21015		

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21015	Continued From page 6 The NA-A, B, and C were not observed to wash their hands between passing and setting up resident meal tray during the meal experience. Review of the facility policy entitled Cross-Contamination copywriter dated 2011 read: "Use spatula, tongs or single-use food grade disposable gloves when handling raw or ready to eat food." On 12/30/11 at 12:20 p.m. the certified dietary manager (CDM) and the registered dietician (RD) verified the staff should not directly touch the resident's food during service. The RD stated the staff receives education upon hire regarding how to safely butter a resident's bread without touching it. She verified the facility policy had not been followed. A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived.	21400		

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21400	Continued From page 7 Conditions of Waver: - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 5 residents (R38) received the required tuberculosis (TB) screening to show they were free from TB at the time of admission. Findings include:	21400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21400	Continued From page 8 R38 was admitted to the facility on 11/9/11. R38 did not receive a baseline TB risk factors including current TB symptoms screening within 72 hours of admission. They did receive the two step TB screening according to the licensing rule. The director of nursing (DON) was interviewed at 2:45 p.m. on 12/29/11. The DON confirmed R38 should have been assessed for current symptoms, and risk factors of TB. SUGGESTED METHOD OF CORRECTION: The infection control nurse along with the DON could review all resident files to ensure all residents have received the required screening for TB. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21400		
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the	21415		

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21415	Continued From page 9 "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 8 nursing assistants (NA's) received required screening to ensure they were free from tuberculosis (TB) prior to working with residents. The screening is to include a two-step tuberculin skin test (TST.)	21415		

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21415	Continued From page 10 Findings include: NA-E received the first step TST on 6/13/11, and was read as negative on 6/15/11. There was no documentation in the employee file or provided by the facility that a second step TST had been administered. NA-F received the first step TST on 8/2/11, and was read as negative on 8/5/11. There was no documentation in the employee file or provided by the facility that a second step TST had been administered. The director of nursing (DON) was interviewed at 10:50 a.m. on 1/3/12. The DON confirmed the forms in the employee files were not complete and would look for further documentation of second step TST. None was provided. SUGGESTED METHOD OF CORRECTION: The DON along with the infection control nurse could review employee files to ensure all staff are up to date with TB screening. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21415		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced	21695		

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21695	Continued From page 11 by: Based on observation and interview, the facility failed to maintain the facility in a state of good repair to promote a comfortable and sanitary environment for residents, staff and visitors. This affected 11 of 30 resident rooms (4, 5, 10, 11, 16, 20, 22, 26, 27, 30 and 31) in the facility. Findings include: The following observations were made in resident rooms on 12/27/11: Rooms 4, 5, 10, 26 and 31 contained bathroom doors that were badly scraped leaving rough and sharp edges exposed. Rooms 4, 16, 26, and 27 had missing paint around bathroom light fixtures and/or sinks. Rooms 10, 11, 20, 22, 30, 31 contained badly scraped walls with plaster exposed or large holes in walls. A facility tour was conducted at 2:20 p.m. on 12/30/11, with the maintenance manager. The maintenance manager confirmed the above findings and indicated that repairs are needed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing, Housekeeping and/or designee could monitor to assure the facility is clean, sanitary and well maintanined. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21695		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide	21915		

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21915	Continued From page 12 assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to encourage the development of a family council which would advise the facility and make recommendations regarding facility policies, with the potential to affect all 47 residents in the facility. Findings include: During interview on 12/27/11 at 1:00 p.m. the director of nurses stated the facility had a family council in the past but did not currently have a family council. Review of the Family Council Reports indicated the last meeting was held on 9/27/10. At 1:00 p.m. on 1/3/12, the licensed social worker stated the facility had not attempted to establish a family council in 2011. She stated the facility was planning on attempting to establish a meeting in January 2012. SUGGESTED METHOD OF CORRECTION: The Administrator could review and revise policies and procedures regarding attempts to develop a family council and attempts documented yearly. The quality assurance committee could randomly audit and make recommendations regarding family council formation.	21915		

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21915	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21915		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this	21980		

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21980	Continued From page 14 subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and report allegations timely to the designated state authority of resident to resident suspected abuse for 3 of 3 residents (R14, R46, R29) in the sample and for suspected staff to resident abuse for 1 of 1 resident (R18) in the sample who had a potential sexual abuse incident with staff. Findings include: R14 had informed the facility on 9/19/11 of an allegation of sexual abuse and the facility had not reported it timely to the State Agency. An incident report dated 9/19/11 revealed R14 reported to a registered nurse (RN) at 4:45 p.m. a male resident yelled at her and followed her into her room. The facility licensed social worker (LSW) interviewed R14 (time and date not indicated) regarding the incident. R14 also informed the LSW of two other incidents involving the same male resident, but was not sure of the	21980		

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21980	Continued From page 15	21980		

dates of the incidents. R14 reported the previous week the same male resident had exposed himself to her in the south lounge at which time R14 left the room. The other incident reported by R14 that occurred approximately 3 weeks earlier was reported to the LSW. R14 stated that same male resident grabbed her arm while touching his groin and stated, " You need some sex." R14 indicated to the LSW that she feels scared as she doesn't know how strong the male resident is or what he will do. R14 also stated she felt especially unsafe once she has taken her sleeping pills because she sleeps soundly. This incident was reported to the designated State Agency (SA) at 3:30 p.m. on 9/20/11 which was 22.75 hours after the original report.

The director of nursing (DON) was interviewed at 7:50 a.m. on 12/29/11. The DON indicated R14 has cognitive impairment related to her inability to care for herself and history of alcohol abuse. The DON also stated R12 has a history of urinating in garbage cans in the common areas of the facility and that R14 may have misinterpreted his actions. The DON was also interviewed at 1:00 p.m. on 12/30/11. The DON stated R14 has some dementia due to alcoholism and is very manipulative. The DON also stated there are inconsistencies in R14's stories and that anyone could be a good liar.

The LSW was interviewed at 12:55 p.m. on 12/30/11. The LSW stated R14 tends to hear what she wants to hear out of a conversation, and reports that R14 will come and tell her the same stories daily, but is not aware of her making things up to get others in trouble. In addition, the LSW stated that R14's cognitive level is in question since she repeats stories even though her brief interview for mental status (BIMS) was

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21980	Continued From page 16 normal on 12/22/11. The LSW further indicated she was unaware of the requirement to report to the SA immediately. The LSW stated that she was informed she had 24 hours to investigate the incident prior to reporting to the SA. R46 was physically hit by R22 on 8/25/11 at 5:15 p.m. and this allegation of abuse had not been reported timely to the designated State Agency. Review of an incident report dated 8/25/11, at 5:15 p.m., R46 was seated in an office listening to music. R22 went into the office and yelled shut up to R46 several times. Staff heard yelling and went to the office and witnessed R22 grab R46 by the upper arm and hit R46 in the upper chest and the right lower lip. R46 received reddened marks on the arm, chest and lower lip. This incident was reported to the State Agency at 1:00 p.m. on 8/26/11, which was 19.75 hours after the original report. The DON was interviewed at 8:09 a.m. on 12/29/11, and confirmed the time of the incident reporting to the designated State Agency was the next day and not immediately on being notified of the allegation of abuse. R29 had reported an allegation or abuse to the facility on 9/19/11. However, the facility had not reported the allegation of abuse timely to the State Agency. Review of an incident report dated 9/19/11, revealed R29 was heard yelling in his room at 6:20 p.m. RN-A went into the residents room and noted R29 standing near his bed with blood on his face, hands, clothing and the floor. R29 reported the " Big guy " hit me and R29 left his room and "stomped" down the hall toward the	21980		

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21980	Continued From page 17 lounge, and appeared very upset. At this time RN-A noted R50 walking down the hall toward the lounge. The LSW asked R29 to tell her what happened and he stated R50 was in his room digging in his closet. R29 told R50 to leave and when R50 didn't leave, R29 attempted to push him from the room. R29 stated R50 then hit him in the face then R50 left the room. R29 received a small abrasion of the left side of his nose, and blood was noted on the floor, and R29's face, hands and clothing. The summary of the investigative findings stated R29 alleged R50 hit him, however there were no witnesses, and it has been noted by staff R29 is not always reliable. This incident was reported to the SA at 2:30 p.m. on 9/20/11, which was 20 hours and 10 minutes after the original report. The DON was interviewed at 8:19 a.m. on 12/29/11, and stated R29 is not credible. When questioned if R29 had bleeding and was it from being hit by R50? The DON replied she had not completed the investigation, but confirmed she had reviewed the report completed by other staff, and offered no further information. At 12:05 p.m. on 12/29/11, further information was provided by the DON and administrator (ADM) The DON stated R29's injury was not serious and required no medical attention. The DON further stated the blood could be explained by R29 not making good choices, doing things to get attention, and abuse could not substantiate since R29 could have inflicted the injury upon himself. R18 had an allegation of abuse by staff. The facility was informed of the allegation of abuse on 11/3/11 however; the facility had not reported this allegation of abuse timely to the State Agency. Review of a verification of investigation form (no	21980		

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21980	Continued From page 18 incident report available) dated 11/3/11, revealed that at 2:30 p.m. a nursing assistant (NA-D) reported to the LSW that on 10/27/11 (no time listed); she was assisting NA-E with R18. NA-D stated NA-E pulled R18 forward to put a lift sling under his buttocks and placed R18's head between her breasts and said to the resident, " You are right where you want to be." NA-D asked what NA-E meant and NA-E replied "right on my boobs, he likes it." The LSW interviewed R18 who did not recall the incident. The LSW also interviewed both NA's involved and NA-E denied any inappropriate behavior, but stated R18 "well he does get a little frisky with me sometimes" and will sometimes grab her chest and R18 is redirected by telling him that is inappropriate, "those are mine and you can not touch them." Both NA-D and E were re-educated on appropriate behavior and timely reporting of incidents. This possible abuse incident had not been reported to the designated State Agency. The DON was interview at 8:22 a.m. on 12/29/11. The DON confirmed she did not interview any other staff members or residents regarding inappropriate behaviors and the investigation was not broadened to include other staff members and residents due to not wanting to involve other staff in disciplinary actions concerning NA-E. The DON further stated that NA-E was re-educated on appropriate behaviors and NA-D was given a verbal warning regarding timely reporting. In addition, the DON stated the re-education of both staff members was part of the investigation, and that the investigation was complete. Review of the facility policy titled Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of	21980		

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21980	Continued From page 19 Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements, dated 10/11, incorrectly directed the staff to report to the State Agency (SA) immediately (not to exceed 24 hours from the time initial knowledge that the incident occurred was received). In addition, the policy states any infliction of injury, and includes resident to resident abuse (regardless of whether serious harm occurs). In addition, any sexual contact between a facility staff person and a resident is abuse and requires the staff person to be placed on immediate leave until an investigation is completed. Based on interview and document review, the facility failed to thoroughly investigate and report allegations timely to the designated state authority of resident to resident suspected abuse for 3 of 3 residents (R14, R46, R29) in the sample and for suspected staff to resident abuse for 1 of 1 resident (R18) in the sample who had a potential sexual abuse incident with staff. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the procedure for reporting to state agency and the administrator in a timely manner. Review the policy and educate staff and provide monitoring to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be	21990		

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21990	Continued From page 20 considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by:	21990		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by:	21995		

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22000	Continued From page 21	22000		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00182	A. BUILDING _____ B. WING _____	01/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OTTER TAIL LAKE	28930 COUNTY HIGHWAY 145 BATTLE LAKE, MN 56515

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22000	Continued From page 22 of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement policies and procedures to investigate and report resident to resident altercations for 3 of 4 residents (R14, R29, R46) in the sample and 1 of 1 resident (R18) in the sample with an allegation of staff to resident abuse. The failure to develop and implement vulnerable adult policies has the potential to affect all 47 residents in the facility at the time of the survey. Findings include: The facility failed to ensure the abuse/neglect policy correctly directed staff to report incidents of potential abuse immediately to the designated State Agency (SA.) Review of the facility policy titled Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements, dated 10/11, incorrectly directed the staff to report to the State Agency (SA)	22000		

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22000	Continued From page 23 immediately (not to exceed 24 hours from the time initial knowledge that the incident occurred was received.) In addition, the policy states any infliction of injury, and includes resident to resident abuse (regardless of whether serious harm occurs.) In addition, any sexual contact between a facility staff person and a resident is abuse and requires the staff person to be placed on immediate leave until an investigation is completed. R14's incident report dated 9/19/11 was reviewed and it revealed an allegation of resident to resident abuse was reported to staff at 4:45 p.m. and reported to the SA at 3:30 p.m. on 9/20/11 which was 22.75 hours after the original report. The LSW was interviewed at 12:55 p.m. on 12/30/11. LSW indicated she was unaware of the requirement to report to the SA immediately. The LSW stated that she was informed she had 24 hours to investigate the incident prior to reporting to the SA. R46's incident report date 8/25/11 was reviewed and it revealed an incident of resident to resident abuse was reported to staff at 5:15 p.m. and reported to the SA at 1:00 p.m. on 8/26/11, which was 19.75 hours after the original report. The director of nursing (DON) was interviewed at 8:09 a.m. on 12/29/11, and confirmed the time of the incident reporting to the designated State Agency was the next day (8/26/11 at 1:00 p.m.) and not immediately on being notified of the allegation of abuse. R29's incident report dated 9/19/11 was reviewed and it revealed an allegation of resident to resident abuse was reported to staff at 6:20 p.m. and reported to the SA at 2:30 p.m. on 9/20/11, which was 20 hours, 10 minutes after the original	22000		

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22000	Continued From page 24 report. On 12/29/11 at 8:19 a.m. the DON was interviewed and it was learned that the DON had not completed the investigation nor had reported the incident to the administrator or designated State Agency immediately. R18's verification of investigation form (no incident report had been completed) dated 11/3/11 was reviewed and it, (no time listed) revealed an allegation of staff to resident abuse was not reported to the SA. An interview was conducted at 11:00 a.m. on 12/29/11, with the administrator (ADM) and director of nursing (DON). The policy regulations were discussed and clarified that they lacked the correct information concerning the reporting the potential abuse and or neglect to be reported immediately to the designated State Agency. SUGGESTED METHOD FOR CORRECTION: The Director of Nurses and/ or the Social Worker could review the abuse policy and up-date it to include reporting to the designated state agency and administer immediately. Then to educate all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s). TIME PERIOD FOR CORRECTION: Twenty one (21) days.	22000		