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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XSD9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - TWIN RIVERS**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

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)

6. DATE OF SURVEY **2/14/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (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
X 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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 :
Tim Rhonemus, HFE NE II — 2/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 3/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Provider Number: 24-5298

Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. The facility's request for a continuing waiver involving the deficiency cited at F458 is recommended for approval. Documentation supporting the waiver request is attached. Please refer to the CMS 2567B. Effective January 17, 2014, the facility is certified for 56 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245298

February 27, 2014

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

Dear Mr. Gershone:

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 January 17, 2014, the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 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,

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 27, 2014

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

RE: Project Number S5298025

Dear Mr. Gershone:

On December 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 12, 2013. 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 February 14, 2014, 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 a standard survey, completed on December 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 12, 2013, effective January 17, 2014 and therefore remedies outlined in our letter to you dated December 26, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245298	A. Building B. Wing	2/14/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0167 Reg. # 483.10(g)(1) LSC	12/13/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	01/17/2014	ID Prefix F0356 Reg. # 483.30(e) LSC	01/17/2014
ID Prefix F0371 Reg. # 483.35(i) LSC	01/17/2014	ID Prefix F0458 Reg. # 483.70(d)(1)(ii) LSC	01/17/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By ✓ State Agency	Reviewed By AZ	Date: 2/25/14	Signature of Surveyor:	Date: 2-14-14
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
12/12/2013				

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00866	A. Building B. Wing	2/14/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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 20180 Reg. # MN Rule 4658.0055 Subp. LSC	Correction Completed 01/17/2014	ID Prefix 21015 Reg. # MN Rule 4658.0610 Subp. LSC	Correction Completed 01/17/2014	ID Prefix 21540 Reg. # MN Rule 4658.1315 Subp. LSC	Correction Completed 01/17/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency ✓	Reviewed By [initials]	Date: 2/25/14	Signature of Surveyor: [signature]	Date: 2-14-14
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
12/12/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XSD9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - TWIN RIVERS**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

4. TYPE OF ACTION: 2
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)

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

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
X 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
X 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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 :
Kathy Sass , HFE NE II — 1/7/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 3/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00454 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5298
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. The facility's request for a continuing waiver involving the deficiency cited at F458 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7208

December 26, 2013

Mr. Ernest Gershone, Administrator
Golden LivingCenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

RE: Project Number S5298025

Dear Mr. Gershone:

On December 12, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7338
Fax: (320) 223-7348

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 January 21, 2014, 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 January 21, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 12, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

(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 verifcation 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	Twin Rivers objects to the allegations of non-compliance in this Statement of Deficiency and that this statement of deficiency was correctly cited and is also not to be construed as an admission against interest of the facility, the administrator of any employees, agents or other individuals who draft or may be discussed in this Response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth or any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction solely because of the requirements under State and Federal law that mandate submission of a plan of correction within ten days of the survey as a Condition of Participation in Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with allegations of non-compliance or admissions by the facility.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the most recent state survey results were posted. This had the potential to affect all 48 residents currently residing in the facility and all visitors. Findings include: During observation on 12/9/13 at 1:30 p.m. a	F 167	1/17/14 BT accepted	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kit Abernathone — TITLE: Executive Director — (X6) DATE: 1-7-14

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 167	Continued From page 1 three ring binder was sitting on a table near the front entrance of the facility. Inside of the binder was the state survey results dated 2/24/12. During interview on 12/9/13 at 5:00 p.m. the Administrator stated the most recent state survey had been on 10/18/12, and verified the survey results posted at the facility were from 2/24/12 and was not the most current state survey results. The administrator stated he thought he had looked at the survey results in the binder " about 10 days ago " and thought the most recent state survey had been posted at that time. The administrator stated he was responsible for ensuring the most recent state survey results were posted and was unsure how the state survey from 2/24/12 got into the binder.	F 167	**F167** : Right to survey results-readily accessible Nursing staff is receiving education on the right to survey results and the need to have them readily accessible. ED (Executive Director) placed survey results in book by front entrance prior to survey exit. ED or designee to audit placement, provide copies and/or update as needed. Updates to location and availability of survey results added to the monthly facility news letter. Corrective action completed 12-12-13. Executive Director is responsible for continuing compliance.	12/13/13 RA
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	**F329** : Unnecessary drug usage: monitoring Nursing is receiving education on antipsychotic medications use on residents who have an adequate indication of the use, behavior monitoring and proper documentation. Consultant Pharmacist will continue to do monthly audits of all charts. All follow ups to these recommendations will be viewed by DNS (Director of Nursing Services) or designee. All recommendations of increase or decrease of antipsychotic medications with rationale will be reviewed with medical director at QAPI meetings. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Corrective Action to be completed by January 17, 2014. Director of Nursing is responsible for continued compliance	per TC 1/13/14 Erin Gershone allowed changes to POC - BT

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F 329	Continued From page 2 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R47) who received an antipsycotic had a adequate indication for use of this medication at the current dose. Findings include: R47's quarterly Minimum Data Set (MDS) dated 9/12/13, identified no cognitive impairments or behavior problems, but received antianxiety medication daily. During observation on 12/11/13, at 5:57 p.m. R47 was observed lying in her bed and appeared calm. She stated she had to stay in bed because the doctors at the Mayo Clinic told her to. During observation on 12/12/13 at 9:00 a.m. R47 again was in bed, very calm and did not demonstrate any behaviors. Review of the physician orders dated 11/4/13, identified R47 was on Zyprexia 2.5 mg (antipsycotic) every day, which started on 1/9/13 for dementia with psychotic agitated features. R47's care plan dated 3/27/12, identified a problem of, "...behaviors which include Yelling	F 329		

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F 329	Continued From page 3	F 329		

during care, resisting medications, bathing. I have a history of delusional thoughts." There was no indication of what specific behaviors R47 was displaying for the use of the Zyprexia. The care plan did not identify what non-pharmacological interventions could be used to assist R47 with her delusions.

Review of the monthly Mood and Behavior Assessment form from 6/12/13 to 12/3/13, identified the resident was pleasant and cooperative, and could be resistive to cares, treatment and medications. The forms also identified, R47 had "No behaviors noted in care trackers in past 30 days."

Review of the facility progress notes from 7/8/13 to 12/11/13 only identified R47 refused her medications on 9/12/13 and refused her cranberry juice on 9/24/13.

The monthly pharmacist forms identified on 9/17/13, the pharmacist made recommendations of reducing the current medication dose of Zyprexia 2.5 mg to every other day. "If the medication can not be reduced at this time, please provide rational." The response from the physician was "Rejected, Please continue current orders."

During an interview on 12/12/13 at 2:05 p.m. nursing assistant (NA)-E, stated R47 had no behaviors. At 2:30 p.m. LPN-D stated R47 had no behaviors.

During interview on 12/12/13 at 12:56 p.m. licensed practical nurse (LPN)-C, stated that R47 physician has ordered Zyprexia for her dementia with delusions, and has not changed her dose.

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F 329	Continued From page 4 On 12/12/13 at 10:00 a.m. LPN-B stated that the behavior monitoring should be on the medication or treatment sheets, but there was no monitoring identified on these forms. During an interview on 12/12/13 at 1:04 p.m. the assistant director of nursing (ADON) stated when R47 came here she had a lot of delusions. The pharmacist had recommended on 9/17/13 to decrease the Zyprexia to every other day. R47's physician did not respond to the pharmacist recommendations, and was unsure why. During an interview with the pharmacist on 12/12/13 at 1:30 p.m., she stated that she had recommended to the physician in September 2013, to decrease R47's Zyprexia but the physician rejected the request, and did not provide a rational. She stated she will requesting this dose reduction again.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	**F 356** - Posted nurse staffing information All staff are receiving education on the posting of direct care staff by the facility's main entrance. Specific shift times have been added to the form and identification of who is the nurse in charge have been added to this report. Nursing staff are receiving education on charge nurse duties and responsibilities. New updates on assigned charge nurse is indicated on the posted daily nursing schedule. Weekly audits will be conducted to check for the posting availability and accuracy. Corrective Action to be completed by January 17, 2014. ED or designee will be responsible for this compliance.	

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F 356	Continued From page 5 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based interview and document review the facility failed to ensure the daily staff posting indicated actual number of hours worked. This had the potential to affect all 41 residents currently residing in the facility as well as all visitors. Findings include: Upon initial tour 12/9/13 at 3:10:00 p.m. the facility daily staff posting near the facility entrance, on a bulletin board which identified registered nurse (RN), licensed practical nurse (LPN) and nursing assistant (NA). There were shifts identified as "1st, 2nd, and 3rd." There was no indication of what actual hours the 1st, 2nd and 3rd shift were. During interview 12/9/13 at 3:20 p.m. the director of nursing (DON), stated they have always completed the nurse staff hours as 1st, 2nd and	F 356		

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F 356	Continued From page 6 3rd shift. She verified they do not have actual hours worked listed on the form. The DON stated, that 1st shift is 6:30 a.m. to 3:00 p.m.; 2nd shift is 2:15 p.m. to 10:45 p.m. and 3rd shift is 10:30 p.m. to 7:00 a.m. During interview on 12/9/13 at 3:30 p.m. NA-A, who is the staffing coordinator, verified they do not have actual hours worked on their staff posting form.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to store cereal in pest proof containers for three of three cereals (oats, bran, and rice cereals) that were stored in open and undated manufacturers bags. In addition the facility failed to appropriately test sanitizer water used to clean dining surfaces. This had the potential to affect 51 of 51 residents who ate in the dining area. Findings include:	F 371	**F 371**: Food procedure, Sanitary conditions in kitchen Cereal storage was changed to cereal kept in secured, sealed, air tight bin in bags that are twist tied and dated upon opening. Dietary staff are being educated on proper cereal storage. All dining staff are being educated on proper procedure for testing and documenting the Klean Pail sanitizer level. This will include maintaining a daily log of sanitizer scores. Director of Dining Services or designee will monitor sanitizer results daily to ensure that results are within acceptable parameters. Corrective action will be completed January, 17th 2014. Responsibility assigned to Director of Dining Services or designee.	

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During an initial kitchen tour on 12/9/13 at 1:30 p.m. three bags of cereal in manufacturers bags were open and undated. There was one bag of toasted oats, one bag of crisp rice, and one bag of bran flakes. The three bags were secured only with twist ties, and were sitting atop a box in the dry goods storage. Additional cereal was stored on the kitchen counter top in airtight dispensing containers.

On 12/12/13 at 10:00 a.m. the corporate registered dietitian (CRD) stated the facility had just changed cereal vendors and the cereals now came in different packaging and (the facility) had not adapted to the change yet.

During observation on 12/11/13, at 8:12 a.m. dietary aide (DA)-A was observed wiping off tables with a cloth from a Klean Pail (bucket) as resident's finished their breakfast. DA-A stated she had prepared the sanitized water, by putting the hot water on first, because the water needs to be hot enough. DA-A did not test the sanitizer level in the water to assure she had the proper chemical concentration for cleaning and does not remember being trained to do this.
-At 8:15 a.m. the facility registered dietician (RD)-A was asked to test the Klean Pail sanitizer level in the bucket currently being used to wipe off tables. RD-A retrieved test strips from the kitchen. The strip was held in the solution by the RD-A after two minutes it was brought out and tested approximately 100 parts per million (PPM), she then put it back in the sanitizer and after an additional two minutes (a total of four minutes)

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minutes tested at 200 PPM for the majority of the strip and close to 400 PPM along the outside edges of the strip.

On 12/12/13 at 10:00 a.m., the RD-A stated she did not know why the test strip took four minutes to show adequate results. The corporate registered dietician (RD)-B stated the sanitizer was tested on 12/11/13, and did function at the 200 PPM in a short amount of time. RD-B stated the paper can be temperature sensitive, and she wasn't sure what the temperature was when it was tested on Wednesday (12/11/13). The RD-A stated she called EcoLab (vendor for food service safety) yesterday, but has not received a return call, and will have them check the sanitizer.

On 12/12/13, at 1:28 p.m. the Eco lab specialist stated he had just changed the cap to prevent any gassing that may have been happening in the sanitizing solution dispenser. He also provided them (the facility) with the correct test strips for the chlorine sanitizer (bleach based). They were using the Quat test strips which was the test for quaternary ammonia sanitizing solutions. The solution they used the other day was probably correct, but the test strips used to test it were wrong. The sanitizer water was now testing correctly at 50 PPM.

Chlorine Sanitizer solution: mix one teaspoon of chlorine in 1 gallon of water and should be used with warm water (110 degrees Fahrenheit) and tested with chlorine test strips to at least 50 PPM chlorine. (www.health.state.mn.us. www.publichealthmdc.com;

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F 371	Continued From page 9 http://catalog.nationalew.com/catalop/p/EL-23030 40511/ECOlab-QT4 Test Stips sanitizer). Quat Sanitizer solution (quaternary ammonia): mix mix solution according to the directions on the label. Use Quat test strips, dip the test strip in the solution to measure concentration of Quat sanitizer, test between 150-400 PPM Quat. The facility policy dated 2011, titled Cleaning Dining Areas indicated: 1. remove table cloths if needed 2. wash table tops using a warm water detergent.... 3. rinse with a sanitizing solution at the appropriate strength 4. allow to air dry.	F 371		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 80 sq ft of floor space per resident in 8 of 28 resident rooms (rooms 4, 7, 17, 20, 21, 29, 35 and 36) which affected 13 residents (R10, R105, R104, R103, R94, R69, R2, R15, R9, R1, R53, R4, R45) who currently resided in these rooms. Findings include:	F 458	**F 458** Bedrooms measure at least 80 sq ft/resident F458 Golden LivingCenter-Twin Rivers would like to request a waiver under F458 in regard to resident room size. The rooms to be included in this waiver are 4, 7, 17, 20, 21, 29, 35, and 36. These rooms were constructed in 1962 and do not meet the current requirements for square footage in two-bed rooms. There is no method available to increase the size of the rooms without causing hardship on the facility. Granting this waiver would not adversely affect the residents residing in the aforementioned rooms. The residents' health, treatments, comfort, safety and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. The Director of Maintenance is responsible for the monitoring of this waivered requirement.	

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During the entrance conference at 1:30 p.m. on 12/9/13, the facility's executive director stated rooms 4, 7, 17, 20, 21, 29, 35 and 36 remain the same size and "nothing has changed." He stated he would be applying for a waiver for these requirements.

The following double resident rooms did not meet the required minimum square footage per resident:

Room 4 = 150 square feet, 75 square foot per resident, R10 and R105.

Room 7 = 152.5 square feet, 76.2 square foot per resident, R104 and R103.

Room 17 = 150 square feet, 75 square foot per resident, R94.

Room 20 = 150 square feet, 75 square foot per resident, R69 and R2.

Room 21 = 150 square feet, 75 square foot per resident, R15.

Room 29 = 150 square feet, 75 square foot per resident, R9 and R1.

Room 35 = 150 square feet, 75 square foot per resident, R53 and R4.

Room 36 = 155 square feet, 77.5 square foot per resident, R45.

R10 who lived in room 4-1 was interviewed at 6:13 p.m. on 12/9/13 and stated she did not have any problems moving around the room due to it's

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size.

R40 who lived in room 36-1 was interviewed on 12/09/13, at 6:30 p.m., and stated her room is small but she is planning to move to a larger room soon.

R94 who lived in room 17-2 was interviewed on 12/09/13, at 7:00 p.m., and stated she has lived in the room alone and has not had any roommates. She had no concerns with the room size.

R45 who lived in room 36-2 was interviewed on 12/10/13, at 8:30 a.m., and stated she uses a wheelchair and that it is small in her room but is able to move around.

During interview on 12/12/13, at 2:13 p.m. nursing assistant (NA)-D stated it can be hard at times to use the hoyer in the smaller rooms but it is manageable. We just make sure the rooms are set up so we can provide cares and move around in them.

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

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GOLDEN LIVINGCENTER - TWIN RIVERS	**305 FREMONT STREET ANOKA, MN 55303**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Twin Rivers 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. This 1-story building was constructed in 1962 and was determined to be of Type II (111) construction. With an addition of the same type in 1977. It has a partial basement and is automatic sprinkler protected throughout. The facility has fire alarm detection in corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 56 and had a census of 54 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7208

December 26, 2013

Mr. Ernest Gershone, Administrator
Golden LivingCenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5298025

Dear Mr. Gershone:

The above facility was surveyed on December 9, 2013 through December 12, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7338
Fax: (320) 223-7348

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,

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File