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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z6BQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**
2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HENNING**
(L4) **907 MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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

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

6. DATE OF SURVEY **05/26/2015** (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 **42** (L18)

13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 06/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(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 06/08/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/13/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245540

June 4, 2015

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

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 May 19, 2015 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 4, 2015

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

RE: Project Number S5540025

Dear Ms. Gedde:

On April 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 10, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On May 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 4, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 19, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 10, 2015, effective May 19, 2015 and therefore remedies outlined in our letter to you dated April 22, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245540	A. Building B. Wing	5/26/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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) - (4)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/05/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **05/05/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	06/04/2015	38035	05/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/10/2015			

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
245540	A. Building / B. Wing: **01 - MAIN BUILDING 01**	6/4/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0018	**05/19/2015**	ID Prefix Reg. # **NFPA 101** LSC K0029	**04/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0147	**04/15/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/mm	Date: 06/04/2015	Signature of Surveyor: 27200	Date: 06/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/9/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z6BQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**
2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HENNING**
(L4) **907 MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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 **04/10/2015** (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 **42** (L18)

13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 05/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(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 05/13/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

April 22, 2015

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, Po Box 57
Henning, Minnesota 56551

RE: Project Number S5540025

Dear Ms. Gedde:

On April 10, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>Electronic 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;

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 20, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 10, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 10, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

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

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

5540s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	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).	F 225		5/5/15

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

Electronically Signed | 05/01/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(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 225	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify a reportable injury of unknown origin, which required immediate notification to the facility administrator and State agency (SA), and investigation of the injury for 1 of 4 residents (R33) reviewed who sustained an injury of unknown origin. Findings include: R33's quarterly Minimum Data Set (MDS) dated 12/5/14, identified her cognition was severely impaired and she required extensive assistance for most activities of daily living (ADLs) including transfers, bed mobility, dressing and toilet use. The MDS identified R33's active diagnoses included dementia.	F 225	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 Corrections 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	

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F 225	Continued From page 2 A physician progress note dated 1/7/15, noted the following: "Staff stated that over the weekend [R33] was transferred by lifting under her arms and now today she cannot move her left arm and she complains of extreme pain in her left shoulder and there is some swelling noted." The plan was to x-ray the shoulder and refer R33 to physical therapy. R33's Physical Therapy Plan of Care signed 1/8/15, noted, "... [R33] now requires a Hoyer [mechanical lift] to transfer due to the pain... [R33] has L [left] shoulder pain rated at 10 [ten] out of 10 impacting need for [her] to transfer safely." A physician progress note dated 1/20/15, noted the following: "[R33] hurt her shoulder last week. She was sent over to the clinic and had an x-ray which showed shoulder separation. It is still sore this week... She is not able to adduct the left shoulder and it is sore and painful when I passively moved it." The physician's assessment included the following: "ROTATOR CUFF TEAR, MOST LIKELY COMPLETE OF LEFT SHOULDER... she looks like a very poor operative candidate... AC SEPARATION [an acromioclavicular joint separation where the clavicle (collar bone) separates from the scapula (shoulder blade)]... UNCONTROLLED PAIN..." The physician's treatment plan included physical therapy, heat applications, range of motion and Tylenol 1000 mg, three times daily for pain management. During interview on 4/8/15, at 2:31 p.m. the director of nursing (DON) stated she could not	F 225	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: It is the intent of Golden Living Center-Henning to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. R33's complaints of left shoulder pain and decreased mobility were reported to physician on 01/07/15. Imaging of left shoulder occurred on 01/07/15 and pain meds/heat/ice ordered by physician were started. R33 was seen by PT on 01/08/15 for eval: e-stim and gentle ROM treatment plan initiated. Physician updated with results. 01/20/15 pain med changed from prn to scheduled. Once DNS and ED became aware of injury of unknown origin on 04/08/15, investigation was initiated. All residents have the potential to be affected by the deficient practice. Facility staff have been educated regarding the requirement to report alleged violations of abuse/mistreatment, including injuries of unknown origin, immediately to the ED. All staff also educated regarding the requirement to report to state agency immediately, then followed by an investigation into any allegations of abuse/mistreatment and the	

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F 225	Continued From page 3 recall an injury having occurred to R33's shoulder as it was referenced in the physician progress note dated 1/7/15. At 3:48 p.m. the DON confirmed the facility had no incident report, no report of SA notification and no investigation completed in relation to R33's shoulder injury. The DON stated she would initiate an investigation into the origin of R33's shoulder injury at that time. On 4/9/15, at 10:45 a.m. the DON reported she had identified the nurse on duty at the time R33 was sent to the clinic for x-ray on 1/7/15, as registered nurse (RN)-G. During interview on 4/9/15, at 1:25 p.m. RN-G confirmed she was the nurse who sent R33 in for an x-ray on 1/7/15, due to complaints of severe pain and immobility of the left shoulder. RN-G stated she had no knowledge as to the cause of R33's shoulder pain. RN-G stated when she came on duty after the weekend, she found R33 to be complaining of pain and unable to move her shoulder around. She stated, "[R33] was in a lot of pain and wasn't even able to move her arm." RN-G stated that she monitored R33's pain and as the complaints continued, she notified the physician to request she be sent in for an x-ray. RN-G stated she did not tell the physician what caused the injury because she did not know what caused it and she did not know how or why the physician noted in their progress notes that the injury was caused by an under-arm transfer by facility staff. RN-G confirmed the injury met the definition of an injury of unknown origin and required further reporting and investigation. RN-G stated that she completed an incident report and turned the report in to the DON. She was unable to explain why the report was unable to be located. RN-G reported her investigation of the	F 225	results of the investigation and corrective actions taken to be reported to MDH. Audits will be completed immediately on reported incidents and daily review of Interdisciplinary Progress Notes will continue to be reviewed for potential concerns to ensure initiation of report to MDH as appropriate. Any required follow-up or re-education will be completed at that time. Audit results will be presented at QAPI for review. ED or Designee is the responsible party. Corrective Action will be completed by 05-05-2015.	

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F 225	Continued From page 4	F 225		

injury included interviews with the nursing staff present in the facility on 1/7/15. She stated that none of the staff were able to explain what had occurred as none of them had been on duty over the prior weekend, which was when she suspected the injury had occurred. RN-G stated the DON and the facility administrator were present in the facility on 1/7/15, and therefore would have been immediately informed of the incident. RN-G stated the DON was responsible for conducting further interviews of nurses and aides who were on duty over the weekend, in effort to identify the cause of R33's shoulder injury.

On 4/9/15, at 2:15 p.m. the DON again confirmed there was no incident report associated with R33's shoulder injury and confirmed she was not aware of the injury until shown the physician progress note from 1/7/15, during interview with this writer on 4/8/15. She confirmed the injury was not reported to the SA and was not investigated as an injury of unknown origin.

During interview on 4/10/15, at 10:35 a.m. the administrator confirmed she had not been notified of R33's shoulder injury until after the event was brought to the attention of the DON by this writer on 4/8/15. The administrator stated, had she or the DON been aware of the incident when it occurred, it would have been immediately reviewed to determine whether it met the criteria for an injury of unknown origin. She added, if the injury was found to meet this definition, it would have been reported to the SA immediately, with an investigation and corrective action to follow.

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F 225	Continued From page 5 The facility's Abuse Prohibition policy dated 7/13, defined an injury of unknown origin as follows: "An injury sustained by a resident that is not reasonably explained. The source of the injury may not have been observed and/or the resident may not be able to explain the source of the injury. The injury may be suspicious because of the extent or the location of the injury or the number of injuries observed at one time or over a period of time." The policy directed anyone who had knowledge of a resident having sustained a physical injury which was not reasonably explained, to immediately report the incident to the facility administrator. Upon determination of a reportable incident, the facility administrator was to immediately notify the SA and immediately facilitate an investigation, taking corrective action to eliminate any ongoing dangers to the resident.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse prohibition policies and procedures for identification of a reportable injury of unknown origin, which required immediate notification to the facility administrator and State agency (SA), along with investigation of the injury for 1 of 4 residents	F 226	F 226: It is the intent of Golden Living Center-Henning to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	5/5/15

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F 226	Continued From page 6 (R33) reviewed who sustained an injury of unknown origin. Findings include: The facility's Abuse Prohibition policy dated 7/13, defined an injury of unknown origin as follows: "An injury sustained by a resident that is not reasonably explained. The source of the injury may not have been observed and/or the resident may not be able to explain the source of the injury. The injury may be suspicious because of the extent or the location of the injury or the number of injuries observed at one time or over a period of time." The policy directed anyone who had knowledge of a resident having sustained a physical injury which was not reasonably explained, to immediately report the incident to the facility administrator. Upon determination of a reportable incident, the facility administrator was to immediately notify the SA and immediately facilitate an investigation, taking corrective action to eliminate any ongoing dangers to the resident. R33's quarterly Minimum Data Set (MDS) dated 12/5/14, identified her cognition was severely impaired and she required extensive assistance for most activities of daily living (ADLs) including transfers, bed mobility, dressing and toilet use. The MDS identified R33's active diagnoses included dementia. A physician progress note dated 1/7/15, noted the following: "Staff stated that over the weekend [R33] was transferred by lifting under her arms	F 226	R33's complaints of left shoulder pain and decreased mobility were reported to physician on 01/07/15. Imaging of left shoulder occurred on 01/07/15 and pain meds/heat/ice ordered by physician were started. R33 was seen by PT on 01/08/15 for eval; e-stim and gentle ROM plan initiated. Physician updated with results. 01/20/15 pain med changed from prn to scheduled. Once DNS and ED became aware of injury of unknown origin on 04/08/15, investigation was initiated. All residents have the potential to be affected by the deficient practice. Facility staff have been educated regarding the requirement to report alleged violations of abuse/mistreatment, including injuries of unknown origin, immediately to the ED. All staff also educated regarding the requirement to report to state agency immediately, then followed by an investigation into any allegations of abuse/mistreatment and the results of the investigation and corrective actions taken to be reported to MDH. Audits will be completed immediately on reported incidents and daily review of Interdisciplinary Progress Notes will continue to be reviewed for potential concerns to ensure initiation of report to MDH as appropriate. Any required follow-up or re-education will be completed at that time. Audit results will be presented at QAPI for review. ED or Designee is the responsible party. Corrective Action will be completed by 05-05-2015.	

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F 226	Continued From page 7	F 226		

and now today she cannot move her left arm and she complains of extreme pain in her left shoulder and there is some swelling noted." The plan was to x-ray the shoulder and refer R33 to physical therapy.

A physician progress note dated 1/20/15, noted the following: "[R33] hurt her shoulder last week. She was sent over to the clinic and had an x-ray which showed shoulder separation. It is still sore this week... She is not able to adduct the left shoulder and it is sore and painful when I passively moved it." The physician's assessment included the following: "ROTATOR CUFF TEAR, MOST LIKELY COMPLETE OF LEFT SHOULDER... she looks like a very poor operative candidate... AC SEPARATION [an acromioclavicular joint separation where the clavicle (collar bone) separates from the scapula (shoulder blade)]... UNCONTROLLED PAIN..." The physician's treatment plan included physical therapy, heat applications, range of motion and Tylenol 1000 mg, three times daily for pain management.

During interview on 4/8/15, at 2:31 p.m. the director of nursing (DON) stated she could not recall an injury having occurred to R33's shoulder as it was referenced in the physician progress note dated 1/7/15. At 3:48 p.m. the DON confirmed the facility had no incident report, no report of SA notification and no investigation completed in relation to R33's shoulder injury. The DON stated she would initiate an investigation into the origin of R33's shoulder injury at this time. On 4/9/15, at 10:45 a.m. the DON reported she had identified the nurse on

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F 226	Continued From page 8 duty at the time R33 was sent to the clinic for x-ray on 1/7/15, as registered nurse (RN)-G. During interview on 4/9/15, at 1:25 p.m. RN-G confirmed she was the nurse who sent R33 in for an x-ray on 1/7/15, due to complaints of severe pain and immobility of the left shoulder. RN-G stated she had no knowledge as to the cause of R33's shoulder pain. RN-G stated when she came on duty after the weekend, she found R33 to be complaining of pain and unable to move her shoulder around. She stated, "[R33] was in a lot of pain and wasn't even able to move her arm." RN-G stated that she monitored R33's pain and as the complaints continued, she notified the physician to request she be sent in for an x-ray. RN-G stated she did not tell the physician what caused the injury because she did not know what caused it and she did not know how or why the physician noted in their progress notes that the injury was caused by an under-arm transfer by facility staff. RN-G confirmed the injury met the definition of an injury of unknown origin and required further reporting and investigation. RN-G stated that she completed an incident report and turned the report in to the DON. She was unable to explain why the report was unable to be located. RN-G reported her investigation of the injury included interviews with the nursing staff present in the facility on 1/7/15. She stated that none of the staff were able to explain what had occurred as none of them had been on duty over the prior weekend, which was when she suspected the injury had occurred. RN-G stated the DON and the facility administrator were present in the facility on 1/7/15, and therefore would have been immediately informed of the incident. RN-G stated the DON was responsible	F 226		

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F 226	Continued From page 9 for conducting further interviews of nurses and aides who were on duty over the weekend, in effort to identify the cause of R33's shoulder injury. On 4/9/15, at 2:15 p.m. the DON again confirmed there was no incident report associated with R33's shoulder injury and confirmed she was not aware of the injury until shown the physician progress note from 1/7/15, during interview with this writer on 4/8/15. She confirmed the injury was not reported to the SA and was not investigated as an injury of unknown origin. During interview on 4/10/15, at 10:35 a.m. the administrator confirmed she had not been notified of R33's shoulder injury until after the event was brought to the attention of the DON by this writer on 4/8/15. The administrator stated, had she or the DON been aware of the incident when it occurred, it would have been immediately reviewed to determine whether it met the criteria for an injury of unknown origin. She added, if the injury was found to meet this definition, it would have been reported to the SA immediately, with an investigation and corrective action to follow.	F 226		
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	F 329		5/5/15

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F 329	Continued From page 10 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 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure insulin medication administration was performed within the parameters ordered by the physician for 1 of 2 residents (R5) who received insulin; and failed to provide the necessary follow up for an abnormal lab value for a thyroid stimulating medication for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R5's annual Minimum Data Set (MDS) dated 7/11/14, identified R5's diagnoses included diabetes and R5 had received an insulin injection 7 out of 7 days during the assessment period.	F 329	F329: R8's abnormal lab result was faxed to the primary provider on 04/10/15; a phone call was also placed to the provider on that same day requesting that this lab result be addressed again (Rose Lorentz,A-GNP, had reviewed lab result on 02/19/15 previously as documented on TSH lab result in R8's medical record). On 04/13/15 provider responded to the fax sent on 04/10/15 with orders to decrease Synthroid to 88 mcg daily, and to re-check lab value in 1 month with follow-up by provider. All residents at Golden Living Center-Henning have potential to be affected if there is a failure to provide the necessary follow up for an abnormal lab	

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F 329	Continued From page 11 R5's current medication orders dated 3/9/15, identified Lantus 110 units at 8:00 a.m. and hold the dose if blood sugar was less than 120 mg/dl. A second order for Lantus, 50 units at 8:00 p.m. and to hold the dose if blood sugar was less than 120 mg/dl. The March and April 2015, Medication Administration Record (MAR) identified an order with a start date of 12/5/14, directing R5 to receive 110 units of Lantus Insulin at 8:00 a.m. and hold the dose if blood sugar was less than 120 mg/dl. A second order with start date of 1/8/15, identified Lantus 50 units at 8:00 p.m. and to hold the dose if blood sugar was less than 120 mg/dl. Review of R5's blood sugars and MARs identified the following readings below 120 mg/dl, with electronic initials indicating the medication was given rather than held. April 2015: 4/1/15, a.m. blood sugar reading of 94 4/4/15, a.m. blood sugar reading of 105 4/5/15, a.m. blood sugar reading of 77 4/7/15, a.m. blood sugar reading of 77 March 2015: 3/4/15, a.m. blood sugar reading of 82 3/4/15, a.m. blood sugar reading of 82 3/8/15, a.m. blood sugar reading of 91 3/12/15, a.m. blood sugar reading of 114 3/17/15, a.m. blood sugar reading of 119 3/18/15, a.m. blood sugar reading of 97 3/20/14, a.m. blood sugar reading of 114 3/21/15, a.m. blood sugar reading of 52	F 329	value. System change will include weekly review of labs completed within that week for abnormal values and provider response. R5 was assessed for negative outcomes possibly related to receiving insulin outside of designated parameters. Medical Director, Medical Provider, Pharmacy Consultant, ED and resident were made aware of administration errors. Education given immediately to all nurses regarding medication administration and Diabetes. Nurses were not allowed to administer medications by any route until this education was completed. Order was changed to require a blood sugar level be entered prior to administering Lantus insulin. All residents at Golden Living Center-Henning have potential to be affected if medication parameters are not followed. On 04/10/15 when DNS was made aware of failure of parameters being followed, an audit was completed on all residents that receive insulin to ensure that proper parameters are being followed. Will complete random audits to ensure compliance with medication orders x 4 weeks. Will continue audits if concerns are observed. Audit results will be presented to QAPI. DNS or Designee is responsible party. Corrective Action will be completed by 05-05-2015.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 3/22/15, p.m. blood sugar reading 84, and 3/31/15, a.m. blood sugar reading of 92. During an interview on 4/10/2015, at 8:56 a.m. the assistant director of nursing (ADON) reviewed the blood sugar readings and MARs. The ADON verified the blood sugars below 120 mg/dl and the insulin was not held. The ADON agreed the orders to hold the Lantus insulin with blood sugar below 120 mg/dl were not followed. During an interview on 4/10/2015, at 10:46 a.m. the director of nursing (DON) verified staff would have been expected to follow the physician orders. The DON stated, "On several occasions it was not being followed." The DON stated she was initiating education for staff to follow the physicians orders regarding insulin administration "so it does not happen again." The facility policy titled Diabetes Management Guideline, dated 11/13/14, did not address adhering to physician parameters of insulin administration. R8's annual Minimum Data Set (MDS) dated 1/1/15, identified R8 had memory impairment, and diagnoses which included a thyroid disorder (hypothyroidism). Review of R8's laboratory values dated 2/11/15, identified the thyroid stimulating hormone (TSH) level reading was low at 0.04, from a reference range of 0.36 to 3.74. No documentation was found to identify the physician had addressed the	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	04/10/2015

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F 329	Continued From page 13 irregular lab result. R8's medication review identified an order for Synthroid 100 MCG (microgram) daily for hypothyroidism, which started 8/22/14. No documentation was found regarding a dosage change for the Synthroid medication or clinical rational for the irregular lab value. The current physician order dated 2/25/15, identified the continued dose of Synthroid 100 MCG. During an interview on 4/10/2015, at 4:25 p.m. the director of nursing (DON) verified the irregular lab result of 2/11/15; however, could not address why the low TSH level was not addressed by the physician. The DON stated the facility did not have a protocol in place to follow up with physicians when irregular lab levels are not addressed, "we are told they are aware of the labs." The physician could not be reach by phone on 4/10/15, but was contacted via fax with a return fax to the facility dated 4/13/15. The fax directed staff to decrease the thyroid stimulating medication (Synthroid) dose to 88 (MCG) micrograms daily and to recheck the lab value in one month. The requested facility policy was not provided.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		5/5/15

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F 428	Continued From page 14 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the licensed pharmacist failed to identify an irregular lab level related to the use of a thyroid stimulating medication; and failed to identify insulin administration outside the parameters of the physician orders and report these medication irregularities appropriately to the attending physician and the director of nursing to be acted upon for 2 of 5 resident (R8, R5) reviewed. Findings include: R8's annual Minimum Data Set (MDS) dated 1/1/15, identified R8 had memory impairment and had diagnoses which included a thyroid disorder (hypothyroidism). Review of R8's laboratory values dated 2/11/15, identified the thyroid stimulating hormone (TSH) level was low, reading 0.04, from a reference range of 0.36 to 3.74. No documentation was found to identify the physician had addressed the irregular lab result.	F 428	F428: Contacted Pharmacy Consultant to inform her of medication errors on insulin administration for resident #5 and abnormal lab value for resident #8 that was not identified on her monthly review report, and the expectation that she be identifying such areas and providing follow-up. All residents at the Golden Living Center-Henning have potential to be affected if lab results are not properly monitored and followed up on. All residents at Golden Living Center-Henning have potential to be affected if medication parameters are not followed. Audits have been completed on all residents that receive insulin to ensure that proper parameters are being followed. Will complete audits x 4 weeks. Will continue audits if concerns are observed. Audit results will be presented to QAPI. Pharmacy Consultant and DNS or Designee is responsible party.	

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F 428	Continued From page 15 R8's medication review identified an order for Synthroid 100 MCG (microgram) daily for hypothyroidism, started 8/22/14. No documentation was found regarding a dosage change for the Synthroid medication or clinical rational for the irregular lab value. The current physician order dated 2/25/15, identified the continued dose of Synthroid 100 MCG. The monthly Medication Regimen Review Summary indicated the pharmacy consultant conducted a medication review on 4/2/15, and failed to address the TSH level. During an interview on 4/10/2015, at 4:25 p.m. the director of nursing (DON) verified the irregular lab result of 2/11/15; however, could not address why a low TSH level was not addressed by the physician. The DON stated the facility did not have a protocol in place to follow up with physicians when irregular lab levels are not addressed, "we are told they are aware of the labs." The physician could not be reached by phone on 4/10/15, but was contacted via fax with a return fax to the facility dated 4/13/15. The Physician fax directed staff to decrease the thyroid stimulating medication dose to 88 (MCG) micrograms daily and to recheck the lab value in one month. R5's annual Minimum Data Set (MDS) dated 7/11/14, identified diagnosis of diabetes and received an insulin injection 7 out of 7 days during the assessment period. R5's current medication orders dated 3/9/15, identified Lantus 110 units at 8:00 a.m. and hold	F 428	Corrective Action will be completed by 05-05-2015.	

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F 428	Continued From page 16	F 428		

the dose if blood sugar was less than 120 mg/dl. A second order for Lantus 50 units at 8:00 p.m. and to hold the dose if blood sugar was less than 120 mg/dl.

The April 2015, Medication Administration Record (MAR) identified an order with a start date of 12/5/14, directing R5 to receive 110 units of Lantus Insulin at 8:00 a.m. and hold the dose if blood sugar was less than 120 mg/dl. A second order with start date of 1/8/15, identified Lantus 50 units at 8:00 p.m. and to hold the dose if blood sugar was less than 120 mg/dl.

Review of R5's blood sugars and MAR identified the following readings below 120, with electronic initials indicating the medication was given rather than held:

April 2015:
4/1/15, a.m. blood sugar reading of 94
4/4/15, a.m. blood sugar reading of 105
4/5/15, a.m. blood sugar reading of 77
4/7/15, a.m. blood sugar reading of 77

March 2015:
3/4/15, a.m. blood sugar reading of 82
3/4/15, a.m. blood sugar reading of 82
3/8/15, a.m. blood sugar reading of 91
3/12/15, a.m. blood sugar reading of 114
3/17/15, a.m. blood sugar reading of 119
3/18/15, a.m. blood sugar reading of 97
3/20/14, a.m. blood sugar reading of 114
3/21/15, a.m. blood sugar reading of 52
3/22/15, p.m. blood sugar reading 84, and
3/31/15, a.m. blood sugar reading of 92.

The monthly Medication Regimen Review

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F 428	Continued From page 17 Summary indicated the pharmacy consultant conducted a medication review on 4/2/15, and failed to address the concern with administration of insulin when blood sugar levels below 120 mg/dl. During an interview on 4/10/2015, at 8:56 a.m. the assistant director of nursing (ADON) reviewed the blood sugar readings and MAR. The ADON verified the low blood sugars with insulin not held. The ADON Agreed the orders to hold the Lantus insulin with blood sugar below 120 mg/dl were not being followed. During an interview on 4/10/2015, at 10:46 a.m. the director of nursing (DON) verified staff would have been expected to follow the physician orders. The DON stated, "On several occasions it was not being followed." The DON stated she was initiating education for staff to follow the physicians orders regarding insulin administration "so it does not happen again." During a phone interview on 4/10/2015, at 4:35 p.m. the pharmacist consultant verified no documentation was found addressing R5's irregular TSH level. The consultant pharmacist also stated R8's documentation was reviewed for hypoglycemic events; however, the order to hold if blood sugars were less than 120, "were missed."	F 428		
F 465 SS=D	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.	F 465		5/5/15

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	245540	A. BUILDING _____ B. WING _____	04/10/2015

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F 465	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a sanitary environment free of urine odor and cleanable surfaces for 1 of 8 resident bathrooms (S1) reviewed for environment. Findings include: During observation on 04/09/15, at 12:45 p.m. R29's room (S1) and personal bathroom had a strong urine odor. R29's bathroom had a 4 x 3 inch wooden shim wedged between the toilet and the linoleum flooring at the back of the toilet. The wooden shim was discolored and stained from moisture. The neutral/tan colored linoleum was stained dark gray around the back and the sides of the toilet and appeared wet. R29's toilet also had approximately 3-4 inches of caulking missing from around the base of the toilet. During interview on 4/9/15, at 1:00 p.m. maintenance-A (M)-A stated he also smelled urine when he was inspecting the wooden shim and linoleum flooring for moisture. He stated the wooden shim was used to balance the toilet and was left there by the installer. M-A stated the shim should have been cut off. He stated the linoleum was either stained because it was wet underneath or stained from leaking water from the toilet. He stated he did quarterly resident room audits and repaired equipment as needed. He also stated staff utilized the facility work order system to	F 465	F465: The shim under the toilet in Resident 29's bathroom was removed, and the missing caulking was replaced, by Maint. Dir. following his being made aware of these items. Maint. Dir. completed education to plumber of requirement to maintain cleanable surfaces. Maint. Dir. completed a check of all other resident bathrooms to ensure no others had non-cleanable surfaces. Maint. Dir. to complete regular resident room/bathroom audits and to make repairs as needed to maintain a sanitary environment. ED to perform random audits of resident rooms/bathrooms to ensure maintenance needs are being completed to ensure a sanitary environment. Audit results will be presented to QAPI for review. Maint. Dir. is responsible party. Corrective Action will be completed by 05-05-15.	

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	245540	A. BUILDING _____ B. WING _____	04/10/2015

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F 465	Continued From page 19 request repairs. During Interview on 4/10/15, at 4:15 p.m. the director of nursing (DON) stated the facility did not have a policy to direct staff to complete work orders for repair needs. The DON stated it was a standard of practice for identified maintenance needs to be reported to the appropriate department to address the concern. The DON agreed that untreated wood was porous and an uncleanable surface. The DON stated this was not acceptable to be used near the base of a toilet where it could have been easily soiled with a substance like urine.	F 465		

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	245540	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/09/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Golden Livingcenter - Henning 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/01/2015

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Golden Livingcenter - Henning is a 1-story building with out a basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II (111) construction. In 1963 an addition was constructed to the north of the original building, is 1-story, without a basement and Type II (111). In 1988, an addition was constructed to the south that was determined to be of Type II (000) construction which is not separated from the original building. The building is protected throughout by an automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for	K 000		

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K 000	Continued From page 2 automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The facility has a capacity of 42 beds and had a census of 27 at time of the survey. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is MET	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		5/19/15

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K 018	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) section 19.3.6.3.2. This deficient practice could affect the safety of all residents, staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/09/2015, it was observed that The following resident room corridor doors did not fit tightly in into the frames, 1) resident room 15, 2) resident room 31, and 3) resident room 32. This deficient condition was verified by the Maintenance Supervisor.	K 018	K018: Doors identified as not meeting compliance will be replaced with new doors meeting requirements. Doors have been ordered and will be installed upon delivery by contractor. Maint. Dir. will ensure this project is completed. Maint. Dir. to regularly audit all doors to ensure all are in compliance and replace if indicated in order to be in compliance. Corrective action to be completed by 05-19-15.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		4/15/15

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K 029	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/09/2015, observation revealed, that there were two penetration found in the kitchen storage room on the lower level. One of the penetrations is located above some wood shelves located midway along the south wall of the kitchen storage room where two communication wires were passed through the wall. The other penetration is a vertical penetration that was found in the northwest corner of the kitchen storage room around piping. This deficient condition was verified by the Maintenance Supervisor.	K 029	K029: The 2 areas of penetration in the kitchen storage room identified as not meeting proper protection were repaired by Maint. Dir. upon becoming aware of them. Proper materials were used for repair that meet requirements. Maint. Dir. completed audit of facility to identify any other potential areas of penetration. Maint. Dir. to review work completed by contractors to ensure work areas are finished up to meet requirements. Maint. Dir. to complete regular audits to ensure proper protection is provided. Corrective action completed by 04-15-15.	
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		4/15/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	**907 MARSHALL AVENUE, PO BOX 57** **HENNING, MN 56551**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was using unapproved electrical devices that are not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/09/2015, observations revealed that there was a laundry cart located directly in front of a electrical panel and there was an extension cord being used to power a telephone junction box that is located in the lower level mechanical room. This deficient condition was verified by the Maintenance Supervisor.	K 147	K147: 2 areas identified as not meeting requirements have been corrected. The cart in laundry room was moved away from electrical box; staff educated; and reminder posters placed. The extension cord used to power the telephone system box in lower level was removed when the telephone box was moved closer to existing electrical outlet by the provider so that an extension is no longer required. Maint. Dir. ensured the corrective actions were completed. Maint. Dir. to complete regular audits to ensure requirements are being met. Corrective actions completed by 04-15-15.	