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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 2KW8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00480

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245340**
2.STATE VENDOR OR MEDICAID NO.
(L2) **650343800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GALTIER HEALTH CENTER**
(L4) **445 GALTIER AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55103**

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 **10/24/2013** (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)
09/30

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

12.Total Facility Beds **112** (L18)

13.Total Certified Beds **112** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(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 :
Susanne Reuss, Unit Supervisor 12/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/24/2013 (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
09/01/1986
(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.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/30/2013
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5340

At the time of the standard survey completed August 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On September 30, 2013, the Minnesota Department of Health and, on October 24, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 15, 2013, effective September 24, 2013. Therefore, the remedies outlined in our letter dated September 3, 2013, will not be imposed.
See attached CMS 2567B forms for the results of the September 30, 2013 and October 24, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5340 December 24, 2013

Mr. Thomas Thompson, Administrator
Galtier Health Center
445 Galtier Avenue
Saint Paul, Minnesota 55103

Dear Mr. Thompson:

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 September 24, 2013 the above facility is certified for:

112 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 112 skilled nursing facility beds located in rooms
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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 21, 2013

Mr. Thomas Thompson, Administrator
Galtier Health Center
445 Galtier Avenue
Saint Paul, Minnesota 55103

RE: Project Number S5340022

Dear Mr. Thompson:

On September 3, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 30, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 24, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2013, effective September 24, 2013 and therefore remedies outlined in our letter to you dated September 3, 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,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 24, 2013

Mr. Thomas Thompson, Administrator
Galtier Health Center
445 Galtier Avenue
Saint Paul, Minnesota 55103

RE: Project Number F5340021

Dear Mr. Thompson:

On September 3, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 24, 2013 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 August 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 24, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2013, effective September 24, 2013 and therefore remedies outlined in our letter to you dated September 3, 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245340	A. Building B. Wing	9/30/2013

Name of Facility	Street Address, City, State, Zip Code
GALTIER HEALTH CENTER	445 GALTIER AVENUE SAINT PAUL, MN 55103

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 **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/24/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/24/2013**	ID Prefix **F0313** Reg. # **483.25(b)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/24/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/24/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	10/21/2013	16022	09/30/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/15/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245340	A. Building B. Wing 01 - MAIN BUILDING	10/24/2013

Name of Facility	Street Address, City, State, Zip Code
GALTIER HEALTH CENTER	445 GALTIER AVENUE SAINT PAUL, MN 55103

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 Reg. # NFPA 101 LSC K0154	Correction Completed 09/30/2013	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 09/30/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	PS/sd	12/24/13	12424	10/24/13
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
8/13/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2KW8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00480

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245340**
2.STATE VENDOR OR MEDICAID NO.
(L2) **650343800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GALTIER HEALTH CENTER**
(L4) **445 GALTIER AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55103**

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)

6. DATE OF SURVEY **08/15/2013** (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)
09/30

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

12.Total Facility Beds **112** (L18)

13.Total Certified Beds **112** (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: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(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 :
Robyn Woolley, HFE NE II 09/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 09/30/2013 (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
09/01/1986
(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.
00450
(L31)

30. REMARKS
Posted 9/30/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN# 24-5340

At the time of the standard survey completed August 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5698

September 3, 2013

Mr. Thomas Thompson, Administrator
Galtier Health Center
445 Galtier Avenue
Saint Paul, Minnesota 55103

RE: Project Number H5340022

Dear Mr. Thompson:

On August 15, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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:

Susanne Ruess
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-4106

Fax: (651) 215-9697

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 September 24, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 15, 2013 (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 February 15, 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:

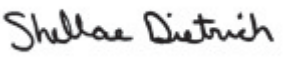
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5340s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALTIER HEALTH CENTER	446 GALTIER AVENUE SAINT PAUL, MN 55103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received services to minimize behaviors and attain psychosocial well being for 1 of 1 resident (R15) observed to demonstrate disruptive behaviors which had the potential to affect others, specifically involving one resident (R57). Findings include: Review of R15's medication sheet, identified R15 as having disruptive or intrusive interactions as	F 250	F250 – 1. Resident #15 has had her behavior care plan reviewed and revised for behaviors that potentially affect others. 2. All other residents with behaviors that may potentially affect others have had care plans reviewed and revised as appropriate. 3. Social Services and Nursing have been re-educated regarding developing care plans with interventions for residents with disruptive behaviors that may impact others. 4. Director of Social Services/Designee will audit 4 care plans per week to ensure appropriate interventions. Results of audits will be reviewed in QPI. Galtier Health Center objects to the allegation of non-compliance. Submission of this response and Plan of Corrections 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 against interest by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute and 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 this allegation by the survey agency. Galtier Health Center respectfully makes it ALLEGATION OF COMPLIANCE on all areas and has written these Plans of Correction to constitute the allegation.	9/24/13

9/13/13
SER

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

Tom Thyse — Admin — 9/10/13

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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F 250	Continued From page 1 evidenced by the target behaviors listed on the current medication sheet #1. calling for help, repeats sentences, wanders into others rooms and #2 follows staff up and down corridor, unable to be redirected. R15's care plan for Mood and Behavior, dated 4/3/13, directed staff to monitor for signs and symptoms of deprssion (sadness, tearful, weight loss and negative statements). Monitor for anxiety changes and update MD (medical doctor)/NSG (nursing)/son, redirect and offer snacks if available, 1 to 1's prn (as needed), encourage activities, 15 minute checks if needed, utilize staff that work well with her. Review of R15's record identified R15 had a BIMS (brief interview for mental status) minimum score of 14 out of a possible 15 on the most recent assessment dated 7/3/13. Diagnosis for R15 included dementia with anxiety and delusions. R15 weighed 159 pounds and spoke English. R15 received the medication trazodone hydrochloride for anxiety with dementia. On 8/12/15, during supper, R15 was observed to be sitting at the first table in the dining room by the exit door with another resident and the other resident's daughter. R15 had coffee and fruit in front of her. At 5:40 p.m., at the beginning of the meal service, staff were observed to bring room trays to the residents who ate in their rooms. R15 called out to staff, "I see you, I want my meal." R15 repeated louder, "I see you, I want my meal." R15 repeated this several times getting louder and louder. Staff responded to R15 that she would have her food in just a minute. 15 minutes	F 250		

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F 250	Continued From page 2 later, R15 received her plate of food. R15 yelled, "there is no meat, where is my meat?" Although behaviors and interventions had been identified on the medication sheet and the care plan, staff did not redirect R15 when the coffee and fruit in front of her and sitting with another resident's daughter did not minimize R15's disruptive behavior and anxiety. On 8/13/13, breakfast was observed. R15 stopped everyone who came through the door asking for coffee, cookies, coffee not hot enough, wanting eggs and juice. Although there were several staff persons who stopped to help R15, there were no interventions implemented or direction given to R15 to minimize her behavior and decrease the continued anxiety over her food. At 10:20 a.m. R15 and another resident R57 were observed to be the only residents in the dining room. R57 was observed in the entry of the dining room, standing in back of her wheel chair, stooped over the chair, holding on to the arm rests. R15 was sitting by a table in the dining room. R15 looked at R57 and called out, "YooHoo!" When R57 did not respond, R15 looked at R57 and called out again, louder, "YooHoo!" R15 then looked at R57 and said, "Come here!" R57 started moving toward R15 and stopped when her wheel chair was approximately 12 inches from R15. R15 was observed to suddenly and quickly pick up her feet and kick at R57's wheel chair. R15 made contact with the seat of the wheelchair, which caused the chair to move backwards and sideways, running into R57. R57 was observed to lose her balance, shuffled her feet to maintain balance and had a surprised / startled look on her face. When R57 maintained her balance, R57 abruptly stood	F 250		

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F 250	Continued From page 3 straight up and raised her arm with fist clenched and aimed at R15. Surveyor called for staff help and R57 was assisted out of the dining room. The incident was reported to registered nurse (RN)-B. There was no intervention/conversation with R15 to investigate the situation before or after assisting R57 out of the dining room. R57's record was reviewed and revealed R57 had a BIMS of 9 out of a possible 15 on the most recent assessment dated 7/24/13. Diagnosis for R57 included (L) tibial plateau fracture, osteoporosis and chronic pain for which R57 received OxyContin and oxycodone. Documentation indicated R57 weighed 84 pounds, spoke only Vietnamese and had no behaviors identified. Review of the notes in R57's medical record for the 8/13/13 incident, read, "{R57} was in dining room, another resident kicked her w.c. no one was hurt. no injuries, continue to monitor for changes in mood/behaviors." On 8/13/13 an intervention was added to R15's care plan directing staff to provide reassurance and daily schedule with times provided for her meals, snacks, smoking, and activities. On 8/14/13, at 7:20 a.m., R57 was observed in the hallway outside R15's room. R15 was standing in the doorway of the room and said to R57, "Hello stupid!" This verbal confrontation was reported to licensed practical nurse (LPN)-A who stated R15 and R57 were roommates. Staff did not implement any interventions at this time.	F 250		

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F 250	Continued From page 4 Interviews with the day shift staff were conducted on 8/14/13, 11:40 a.m. LPN-A stated "She [R15] always yells for staff but not sure if she yells at [R57.]" 11:43 a.m. interview with housekeeper (H)-A stated, "Yes, I have heard [R15] yell at [R57] if she is in the bathroom and [R15] wants in there right now. She [R15] says what is she [R57] doing in there, get her out!" 11:45 a.m. nursing assistant (NA)-B stated, "I have seen [R15} yell at [R57] and I have reported it to the nurse." 11:46 a.m. LPN-B stated, "When [R15] is in this mood she yells at everyone who is in that room." 11:50 a.m. RN-A stated,"When [R15] is in this mood she is rude, but I have never heard it to her roommate before." 12:00 p.m. NA-C stated, "I have heard her [R15] call her roommate stupid before and I have reported it to the nurse." 12:05 p.m. NA-D stated, "She [R15] yells at everyone and it isn't just specific to her roommate [R57]." At 12:10 p.m. Interview with RN-A, director of nursing (DON) and director of social services (DSS) stated there had been no alternative plan discussed for R15. On 8/14/13 at 12:45 p.m interview with the DON reported a room change was occurring for R15 and the facility would be completing a metabolic profile on R15. A schedule of the days events was prepared for R15 and according to the DSS the schedule seemed to help R15 be calmer and less agitated. 8/15/13, at 2:20 p.m., interview with the social service assistant (SSA)-A stated that R15 was on a supervised smoking program, is involved in activities that staff take her to and that a family member of another resident watches R15 every night when the family member feeds her mother	F 250		

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F 250	Continued From page 5 at supper. SSA-A stated that R15 is anxious about her health and belongings every day and that before this week staff would just deal with R15 as needed. SSA-A stated that a daily schedule plan seemed to be a good idea.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that the plan of care was revised regarding a change in vision for 1 of 3 residents (R20) in the sample who required revision of the plan of care.	F 280	F280 – 1. Resident #20's care plan was revised, however now is expired. 2. All residents with visual impairment have had their care plans reviewed and revised as appropriate. 3. Licensed staff have been re-educated regarding revision of care plans. 4. DON/Designee will audit 4 care plans per week to ensure revisions have been made. Audit results will be reviewed in QPI.	9/24/13

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F 280	Continued From page 6 Findings include: During numerous observations of R20 on 8/12/13, 8/13/13, 8/14/13 and 8/15/13, eyeglasses were not being used or offered. R20's Brief Interview for Mental Status (BIMS) was rated at a 9 out of a possible 15 score for cognitive impairment. R20 was assessed on the Minimum Data Set (MDS) as vision impaired. Able to see large print, but not regular print in newspapers/books. For corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision on the MDS the code was marked as no. R20's care plan titled, "Sensory/Communication" read, no glasses. The nurse aide assignment sheet did not mention glasses. Review of ophthalmology notes for R20 read: 7/3/13, order glasses. 7/13/13, fit for glasses. 7/25/13, new glasses. During interview on 8/15/13, at 1:30 p.m. the director of nursing (DON) explained that residents go down to the vision room in the basement for the eye doctor to do screenings and that the whole chart goes with the resident. The eye doctor writes notes, does the fitting and there was no communication between ophthalmology and the nursing staff. Registered nurse (RN)-B stated not knowing that R20 had new glasses. Nursing did not know that new glasses were given to the resident at the appointment and that was why there was no mention on the care plan or the aide assignment sheet for R20 to wear glasses. During further interview on 8/15/13, at 1:30 p.m. with the DON and RN-B, verified the new glasses	F 280		

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F 280	Continued From page 7 for R20 were not followed through with, which they will take care of immediately.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R97) received urinary incontinence care and positioning as directed by the plan of care. Findings include: R97 did not receive position change or incontinence care for three hours and fifty minutes. R97's Care Area Assessment Summary dated 5/10/13, directed staff: "Res [resident]continues to be identified as at increase risk for pressure ulcer as res [resident] continues to be incontinent of bowel and bladder requires staff to assist check and change every two hours and prn [whenever necessary] as res [resident] does not make needs known d/t [due to]cognitive deficit. Staff assist with check and change along with turn and reposition, pericares on daily basis and anticipate needs. Two assist with all transfers, and assist with turn and reposition in bed every two hours and prn [whenever necessary] Braden	F 282	F282 – 1. Resident #97 is receiving incontinent care and turning and repositioning per plan of care. 2. All residents who require incontinent care and turning and repositioning are receiving those services. 3. Nursing staff have been re-educated regarding incontinent care and turning and repositioning. 4. DON/Designee will audit 5 residents per week for incontinent care turning and repositioning. Audit results will be reviewed in QPI.	9/24/13

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F 282	Continued From page 8 of 17." [Braden scale is a tool used for predicting pressure ulcer risk.] During continuous observations on 8/14/13, from 6:50 a.m. until 10:10 a.m. R97 was observed in a sitting position in a tilt and space wheel chair without a position change. R97 was taken to the dining room at 7:30 a.m. until 8:50 a.m. when she was taken back to the bedroom and was set in front of the television. R97 was observed sleeping with head down while sitting up in the chair. At 10:20 a.m., NA-B and NA-C were observed using the mechanical lift to put R97 into bed. Observation of R97's skin revealed bilateral labia flame redness, around the buttocks, gluteal crease and gluteal folds were moist with multiple deep red crevices and creases. The incontinence brief was observed to be wrinkled and wet with urine. Interview with nursing assistant (NA)-C on 8/14/13, at 10:10 a.m. verified the night shift had R97 up by 6:30 a.m. and sitting in the wheel chair by her bed with the television on. NA-C said she went in to R97's room after breakfast and "Pulled on the hoyer sling to shift her position" but did not utilize the tilt in space wheel chair or remove the pressure from R97's buttocks and did not check for incontinence. Interview with the director of nursing (DON) and registered nurse (RN)-B on 8/15/13, at 12:00 p.m. RN-B stated that pulling on the hoyer sling is not an acceptable practice for a position change and stated R97 had a history of denuded [loss of epithelial associated with urine and feces] skin and was to be checked for incontinence every	F 282		

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F 282	Continued From page 9 two hours.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services for 1 of 3 residents (R97) in the sample who were reviewed for positioning. Findings include: R97 did not receive the necessary care and services related to positioning. R97 did not receive position change for three hours and fifty minutes. Document review of R97 identified R97 had history of denuded [loss of epithelial associated with urine and feces] skin,and required incontinence care every two hours. The care area assessment summary dated 5/10/13, read, "Res [resident]continues to be identified as at increase risk for pressure ulcer" and directed staff to turn and reposition R97 every two hours and prn [whenever necessary] as resident does not make needs known due to cognitive deficit. Two assist	F 309	F309 – 1. Resident #97 is receiving incontinent care and turning and repositioning per plan of care. 2. All residents who require incontinent care and turning and repositioning are receiving those services. 3. Nursing staff have been re-educated regarding incontinent care, turning and repositioning and skin integrity monitoring. 4. DON/Designee will audit 5 residents per week for incontinent care turning and repositioning. Audit results will be reviewed in QPI.	9/24/13

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F 309	Continued From page 10 with all transfers, and assist with turn and reposition in bed every two hours and prn. [whenever necessary] Braden of 17." [Braden scale is a tool used for predicting pressure ulcer risk.] During continuous observation on 8/14/13, from 6:50 a.m. until 10:10 a.m. R97 was observed in a sitting position in a tilt and space wheel chair without a position change. R97 was taken to the dining room at 7:30 a.m. until 8:50 a.m. when R97 was taken back to the bedroom and set in front of the television. R97 was observed sleeping with head down while sitting up in the chair. NA-B and NA-C were observed using the mechanical lift to put R97 into bed at 10:20 a.m. Observation of the skin revealed bilateral labia flame redness, around the buttocks, gluteal crease and gluteal folds were moist with multiple deep red crevices and creases from wrinkled incontinence brief, affecting R97's skin integrity. Interview with nursing assistant (NA)-C on 8/14/13, at 10:10 a.m. verified the night shift had R97 up by 6:30 a.m. and sitting in the wheel chair by her bed with the television on. NA-C said she went in to R97 after breakfast and "Pulled on the hoyer sling to shift her position" but did not utilize the tilt in space wheel chair or remove the pressure from R97's buttocks. Interview with NA-B and NA-C on 8/14/13 at 10:30 a.m. verified observation of R97's skin revealed bilateral labia flame redness, around the buttocks, gluteal crease and gluteal folds were moist with deep red crevices and creases. Registered nurse (RN)-B was informed of R97 current skin condition and stated R97 was to be	F 309		

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F 309	Continued From page 11 an every two hour position change. Interview with the director of nursing (DON) and RN-B on 8/15/13, at 12:00 p.m. stated that pulling on the sling was not an acceptable practice for a position change. Further update from the DON included to educate staff to follow the plan of care with repositioning and that staff are to ensure off loading per the plan of care. The DON said a new tissue tolerance assessment had been started today for [R97] and the physician was notified.	F 309		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement treatment/devices to maintain vision for 1 of 3 residents (R20) reviewed for vision. Findings include: During numerous observations of R20 on 8/12/13, 8/13/13, 8/14/13 and 8/15/13, eyeglasses were not provided.	F 313	F313 – Resident #20 has expired. 2. All residents requiring assistance with placing/providing eyeglasses are being provided assistance. Care guides have been reviewed to ensure eyeglasses are listed on the care guide. 3. Nursing staff have been re-educated regarding assistance with eyeglasses. 4. DON/Designee will audit 4 residents with eyeglasses weekly to ensure eyeglass assistance has been provided. Results of audits will be reviewed in QPI.	9/24/13

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	245340	A. BUILDING _____ B. WING _____	08/15/2013

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F 313	Continued From page 12 R20's Brief Interview for Mental Status (BIMS) was rated a 9 out of a possible 15 score for cognitive impairment. R20 was assessed on the Minimum Data Set (MDS) as vision impaired. Able to see large print, but not regular print in newspapers/books. For corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision on the MDS the code was marked as no. R20's care plan titled, "Sensory/Communication" read, no glasses. The nurse aide assignment sheet did not mention glasses. Review of R20's ophthalmology notes read, 7/3/13, order glasses. 7/13/13, fit for glasses. 7/25/13, new glasses. During interview on 8/15/13, at 1:30 p.m. the DON explained that residents go down to the vision room in the basement for the eye doctor to do screenings and that the whole chart goes with the resident. The eye doctor writes notes and does the fitting and there is not communication between ophthalmology and the nursing staff. RN-B was unaware that R20 had new glasses. Nursing did not know that new glasses were given to R20 at the appointment and that was why there was no mention on the care plan or the aide assignment sheet for R20 to wear glasses. Further interview on 8/15/13, at 1:30 p.m. with the DON and RN-B, verified the new glasses for R20 were not followed through with and stated it would be taken care of immediately.	F 313		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

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F 315	Continued From page 13 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely incontinence care for 1 of 3 residents (R97) in the sample who had urinary incontinence. Findings include: R97 did not receive the necessary care and services related to incontinence. R97 had diagnosis of Alzheimer's dementia, was unable to make needs known and staff were directed to anticipate all needs according to the sensory/communication plan of care. R97 did not receive incontinence care for three hours and fifty minutes. During continuous observations on 8/14/13, from 6:50 a.m. until 10:10 a.m. R97 was observed in a sitting position in a tilt and space wheel chair without being checked for incontinence. R97 was taken to the dining room at 7:30 a.m. until 8:50 a.m. when she was taken back to the bedroom and set in front of the television. R97 was observed sleeping with head down while sitting up in the chair until 10:20 a.m., when NA-B and NA-C transferred R97 to bed, using a	F 315	F315 – 1. Resident #97 is receiving incontinent care and turning and repositioning per plan of care. 2. All residents who require incontinent care and turning and repositioning are receiving those services. 3. Nursing staff have been re-educated regarding incontinent care and turning and repositioning. 4. DON/Designee will audit 5 residents per week for incontinent care turning and repositioning. Audit results will be reviewed in QPI.	9/24/13

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F 315	Continued From page 14 mechanical lift. Observation of the skin revealed bilateral labia with flame redness, around the buttocks, gluteal crease and gluteal folds were moist and multiple deep red crevices and creases were noted. The incontinence product was observed to be wrinkled and wet with large amount of urine. Interview with nursing assistant (NA)-C on 8/14/13, at 10:10 a.m. stated the night shift had R97 up by 6:30 a.m. and sitting in the wheel chair by her bed with the television on. NA-C said she went in to R97's room after breakfast and "Pulled on the hoyer sling to shift R97's position" but did not check for incontinence. Interview with NA-B and NA-C on 8/14/13 at 10:30 a.m. verified observation of R97's skin bilateral labia flame redness, and around the buttocks, gluteal crease and gluteal folds were moist, deep red crevices, creases and that R97 was incontinent of large amount of urine. Registered nurse RN-B stated R97 had a history of denuded [loss of epithelial associated with urine and feces] skin and was to be checked for incontinence every two hours. Document review of R97 Care Area Assessment Summary, dated 5/10/13,directed staff that resident continues to be incontinent of bowel and bladder and requires staff to check and change every two hours and when necessary as res does not make needs known due to cognitive deficit.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	Continued From page 15 (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 ensure handwashing was completed during meal preparation and meal service. This had the potential to impact 11 of 11 residents who required a mechanically altered diet of the 72 residents residing in the facility and for 1 of 10 residents observed eating lunch in the 3rd floor dining room. Findings include: Meal preparation was observed on 8/15/13 at 11:00 a.m. Cook-A was observed to touch sudsy water with food debris near the three compartment sink. Cook-A then threw debris into the garbage, touching the lid, which had a white substance on it. Cook-A then continued to operate the mechanical food processor, pushing buttons on the machine. Cook-A then put on gloves, without washing hands, and emptied the mechanical altered hot dogs into two small metal containers. Cook-A then put the metal containers into the warming tray servers. Cook-A reported the mechanical altered hot dog would be ready to serve soon. The dietician, (D)-A was notified of the concern. D-A reported hands should be washed prior to continuing to serve foods after	F 371	F371-1.All staff are being in-service regarding proper hand washing procedures. 2. Daily audits are being conducted by the dietary manager and infection control nurse to assure compliance. 3. Results of audits will be reviewed at the QPI meeting.	9/24/13

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F 371	Continued From page 16 touching the sudsy water and garbage. D-A then directed the mechanically altered hot dog to be disposed of and mechanical food processor rewashed. The facility failed to ensure handwashing was completed prior to serving beverages for 1 of 10 residents reviewed in the third floor dining room for lunch service, R4. On 8/15/13 at approximately 11:30 a.m., a nursing assistant (NA)-A was observed to pick up a wet floor caution sign off the floor. The wet floor sign was yellow with brown spots in some places. NA-A then grabbed two specialized cups out of a bin, put them on the table after removing the regular cups. R4 was then offered a juice beverage, which was poured into the specialized cup. The nurse manager, (RN)-A was notified of the concern. RN-A directed NA-A to dispose of the juice beverage and not serve juice out of the now contaminated specialized cups. RN-A reported hands should be sanitized after touching soiled items before serving food. The Hand Hygiene-Plain Soap and Water Handwash policy, undated, directed staff : "A soap and water handwash will be used :if hands are visibly soiled..." The Hand Hygiene-Alcohol Based Hand Rub policy, undated, directed staff "An alcohol based hand rub is an effective antiseptic agent. EHSI [Extendicare Health Services Inc.] requires personnel to use hand hygiene to remove dirt, organic material and transient microorganisms. Examples of when an alcohol based hand rub may be used: "If hands are not visibly soiled..."	F 371		
F 465	483.70(h)	F 465		

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F 465 SS=E	Continued From page 17 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure one 1 of 1 tub room and 3 of 4 shower rooms were a clean, safe, sanitary, and comfortable environment for residents to bathe. This had the potential to impact 88 out of 95 residents residing at the facility. Findings include: An environmental tour was completed on 8/ 13/13 at 3:45 p.m. with the maintenance manager, (MM). The MM confirmed all findings. The MM reported there were no current plans to renovate or repair the shower and tub rooms. The first floor shower room caulking around the edges of the floor and shower's water handle was browning. The grout space between the tiles around the shower head and water handle were also browning. MM reported "probably needs to be cleaned or replaced." The second floor tub room had a glove tied to the call string, connecting it to the metal cord of the drain stopper. It was browning. The non skid strips on the floor were peeling, rendering it an uncleanable surface. A spot in the ceiling had	F 465	F465-1.The shower and tub rooms were immediately cleaned and the caulking replaced. 2. The non- skid strips were also replaced as was the shower chair. 3. Audits are being conducted by the housekeeping and maintenance director to assure compliance.4. Results will be reported at the QPI meeting.	9/24/13

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F 465	Continued From page 18 cracked paint. The third floor had caulking between the wall and ceiling peeling and reddish brown in two spots, approximately six inches in lengths. The shower chair had red and brownish wheels. The MM described the red/brown matter as "rust." The shower chair straps were originally white but turning reddish brown in spots. MM described the reddish brown area as "rust." The fourth floor metal strip on the floor was reddish brown. The large shower chair wheels were reddish brown. The green shower chair had browning cloth on the back of the seat. MM described the reddish brown area as "rust". MM was not sure what the brown area on the shower chair cloth was but thought it might be "dirt." The HealthCare Services Group, Inc Job to Be Done: Wall Washing policy, dated 1/1/2000 directed staff on how to clean ceramic tile walls: "Cleaning tile walls: -Cleaning solution prepared. Wet wall with clear water, using sponge or rag apply solution to wall and allow to sit. Use scouring pad to scrub wall. Use grout brush to get between tiles, Rinse completely." "Particular attention should be paid to: soap dish area, under spigot, along base area." The Cleanliness and Hygiene procedure, undated, directed staff "After each use, the tub or shower stall (and the shower chair, if one is used) is disinfected. This is important to prevent the spread of infection."	F 465		

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

F 5340021

PRINTED: 09/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING 01 - MAIN BUILDING B. WING _____	08/13/2013

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K 000	INITIAL COMMENTS 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. 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. FIRE SAFETY At the time of this survey, Galtier Health Center was found not to be in substantial compliance with the requirements for participation in Medicare/ Medicaid, 42 CFR, Subpart 483.70 (a), Life Safety from Fire, and National Fire Protection Association (NFPA) Standard 101-2000 edition. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH	K 000	RECEIVED SEP 10 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok 9-16-13	

DC: Exit: 8.15.2013

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

admin | 9-10-13

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 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 This 4-story building was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered. The facility has a capacity of 112 beds. At the time of the survey the census was 92. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K154- 1.Fire watch policy for automatic sprinkler system is now in place for 4 hours or more. 2. This system has it's own policy. 3. The maintenance director will assure compliance.	9/24/13
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on review and interview, the facility failed to develop a separate written policy containing procedures to be followed in the event the	K 154	Galtier Health Center objects to the allegation of non-compliance. Submission of this response and Plan of Corrections 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 against interest by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute and 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 this allegation by the survey agency. Galtier Health Center respectfully makes it ALLEGATION OF COMPLIANCE on all areas and has written these Plans of Correction to constitute the allegation.	

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K 154	Continued From page 2 automatic fire sprinkler system is out-of-service for more than four hours in a 24-hour period. This deficient practice could affect all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 09:00 AM and 1:00 PM on 08/13/2013, it was discovered during an interview with the Maintenance Director (JJ), that the facility has not developed a separate policy and procedures for an out-of-service fire sprinkler system.	K 154		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on review and interview, the facility failed to develop a separate written policy containing procedures to be followed in the event the automatic fire alarm system is out-of-service for more than four hours in a 24-hour period. This deficient practice could affect all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 09:00 AM and 1:00 PM on 08/13/2013, it was discovered during an interview with the Maintenance Director (JJ), that	K 155	K 155- 1.Fire watch policy for fire alarm system is in place. 2. Both systems have individual policies. 3. The maintenance director will assure compliance.	9/24/13

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K 155	Continued From page 3 the facility has not developed a separate policy and procedures for an out-of-service fire alarm system.	K 155		