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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3L76

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00459

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245610**
2.STATE VENDOR OR MEDICAID NO.
(L2) **440886100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST GERTRUDES HEALTH & REHABILITATION CENTER**
(L4) **1850 SARAZIN STREET**
(L5) **SHAKOPEE, MN** (L6) **55379**

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 **02/02/2015** (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)
06/30

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (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
	105			
(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 :
Gayle Lantto, Supervisor 02/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/03/2015 (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
11/08/1996
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/02/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5610

Electronically Delivered: February 3, 2015

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

Dear Mr. Meyer:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 28, 2015 the above facility is certified for or recommended for:

105 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 3, 2015

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

RE: Project Number S5610023

Dear Mr. Meyer:

On January 5, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 25, 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 December 19, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 19, 2014, effective January 28, 2015 and therefore remedies outlined in our letter to you dated January 5, 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.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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
245610	A. Building B. Wing	2/2/2015

Name of Facility	Street Address, City, State, Zip Code
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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 **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **01/20/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/28/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/20/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/28/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/20/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/20/2015**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	02/03/2015	15507	02/02/2015
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
12/19/2014			

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
245610	A. Building B. Wing **01 - MAIN BUILDING 01**	1/25/2015

Name of Facility	Street Address, City, State, Zip Code
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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 K0054	**01/23/2015**	ID Prefix Reg. # **NFPA 101** LSC K0062	**01/23/2015**	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	02/03/2015	25822	01/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
12/18/2014

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245610	A. Building / B. Wing: 02 - 2008 & 2011 ADDITION	1/25/2015

Name of Facility	Street Address, City, State, Zip Code
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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 K0054	01/23/2015	ID Prefix Reg. # NFPA 101 LSC K0062	01/23/2015	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 02/03/2015	Signature of Surveyor: 25822	Date: 01/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/18/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245610	A. Building B. Wing **03 - BLDG THREE NEW ADDITION**	1/25/2015

Name of Facility	Street Address, City, State, Zip Code
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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	Correction Completed **01/23/2015**	ID Prefix	Correction Completed **01/23/2015**	ID Prefix	Correction Completed **01/23/2015**
Reg. # **NFPA 101** LSC K0033		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0054	
ID Prefix	Correction Completed **01/23/2015**	ID Prefix	Correction Completed **01/23/2015**	ID Prefix	Correction Completed **01/23/2015**
Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0147	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	02/03/2015	25822	01/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/18/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3L76

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00459

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245610**
2.STATE VENDOR OR MEDICAID NO.
(L2) **440886100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST GERTRUDES HEALTH & REHABILITATION CENTER**
(L4) **1850 SARAZIN STREET**
(L5) **SHAKOPEE, MN** (L6) **55379**

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 **12/19/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (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
	105			
(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 :
Mary Bruess, HFE NE II 01/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/30/2015 (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
11/08/1996
(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.
03001
(L31)

30. REMARKS

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

Certified Mail # 7010 1670 0000 8044 5476

January 5, 2015

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

RE: Project Number S5610023

Dear Mr. Meyer:

On December 19, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

attained at the time of a revisit;

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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 28, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 28, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 19, 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 June 19, 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
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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

(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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F000. 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. (Continued on additional page)	
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159	**F 159** Policy written to have a cash bag With $50 to have in a secure Location for the Nurse Supervisor To distribute after posted Business hours. Completion date: 12/18/2014 Cash bag purchased and setup With Nurse Supervisor for distribution Of funds after posted hours. Residents will be informed at the next resident council meeting. Nurse supervisors + receptionists will be educated (added with OK of admin.)	1/8/2015

NC accepted as Fan 1/21/15

RECEIVED
JAN 16 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rich Meyer	Administrator	1-16-15

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 159	Continued From page 1 funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents had access to their funds after business hours, potentially affecting 43 residents who had personal funds accounts at the facility. Findings include: R69 reported in an interview she was unable to obtain funds from her personal funds accounts outside of business hours. R112 reported in an interview she was unable to obtain funds from her personal funds accounts outside of business hours.	F 159		

F tag	Deficiency	Action	Completion Date
F000		Initial Comments (Continued) 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 Plan of Correction within ten (10) days of the receipt of the CMS 2567 form 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.	

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

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F 159	Continued From page 2 A receptionist (R)-A was interviewed regarding the facility's resident funds account system on 12/17/14, at 2:20 p.m. She stated, "They need to do it during the time that [business office staff person's name] in our accounting department is here. She is the only one who can get it for the residents." R-A was unsure what happened if that particular staff person was not working. She replied she was "not sure what the policy is on that." R-A stated, "On Saturday we usually just tell them to come back during the banking hours" or wrote down their requests and gave it to the business office staff when they returned to the office on Monday. A sign posted at the reception area indicated businesses hours were Monday through Friday 9:00 to 4:00. R-A had no access to any money such as petty cash should a resident request money in the evenings or on the weekends, and said only office staff had access to resident funds. A licensed social worker (LSW)-A stated in an interview on 12/17/14, at 2:10 p.m. that residents were informed upon admission that they could to open a personal funds account with the facility. She explained that the money was kept at the front desk, but she was unsure when residents could obtain money from their accounts. She thought they would be available into the evening hours and on the weekends, but would have to do more checking to confirm this. She added, "Anytime someone is at the front desk they have the ability to get money." The director of business office was interviewed on 12/17/14, at 3:50 p.m. and stated, "Residents are told they can come to the business office during posted hours to get cash." The director	F 159		

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F 159	Continued From page 3 reported they used to have a money pouch available at the nursing station so residents could get money after business hours, but it was not utilized and a corporate office staff person told them it was not required as long as residents knew when they could get their money. She explained that they limited access to the money to the three business office staff. In addition, she lived 15 minutes from the facility and could come in if residents wanted money outside of business hours, "but I'm not positive a staff member would know that." The director provided a list of 43 residents who had personal funds accounts with the facility. The facility's admission packet contained a document provided to newly admitted residents Resident Trust Account Management Agreement dated 11/13, that indicated "Money will be held in a collective bank account thought the Business Office. Funds will be available for Resident's use during posted hours according to the following guidelines...." The facility's 11/96 Resident Trust Account policy noted "A petty cash account shall be maintained for cash withdrawals during business days between the hours of 9:00 to 4:00 p.m."	F 159		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and	F 164		

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F 164	Continued From page 4 meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote personal privacy of medical information for 3 of 3 residents (R150, R167, R78) who had confidential information posted in a non-confidential manner. Findings include: R150's shared resident room was observed on 12/16/14, at 1:42 p.m. A handwritten sign hung on wall next to the bed with confidential information that read, "Please lotion [R150's] legs and arms each night. Thanks..Her skin is crispy." On 12/18/14, at 7:32 a.m. morning cares were	F 164	F 164 In order to comply with the regulation that St. Gertrude's must ensure that confidential information is communicated in a manner that respects the resident right to privacy, including their accommodations (posting of information in their rooms), St. Gertrude's will do the following: • Signage in residents (R150, R167, R78) rooms were removed or placed inside the resident's closet doors. • Families were informed via phone call or in person that Continued on next page	1/20/2015

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F 164	Continued From page 5 observed for R150, and the sign regarding applying lotion to R150's skin remained posted. A handwritten sign was also hung on the bathroom wall which read, "No male care givers." R150's quarterly Minimum Data Set (MDS) dated 9/12/14, noted R150 had dementia with severe cognitive impairment and depression, and required extensive assistance with bed mobility, transferring, dressing, personal hygiene and toileting. RN-A was interviewed on 12/19/14, at 11:30 a.m. and observed R150's room. She stated she was unaware of the sign regarding applying lotion to R150's skin, and said R150's family member had posted the sign on the wall. RN-A reported she had hung the sign on the bathroom wall, and informed R150's family it was there. R167's shared resident room was observed on 12/16/14, at 2:00 p.m. and a handwritten sign hung on the wall outside the bathroom door with the following confidential information displayed" "Attention: NAR [nursing assistant/registered] staff. Please take res [resident] to toilet even if he says he is fine. He is incontinent of urine and will say that he is fine even when he is not. Thank you per family/nurse request." R167's annual MDS dated 10/11/14, identified the resident had dementia with severe cognitive impairment, and required extensive assistance with bed mobility, transferring, dressing, personal hygiene and toileting. During interview on 12/19/14, at 11:36 a.m. RN-A stated she had observed R167's room and was also unaware of the sign regarding toileting R167.	F 164	these changes were made. • In addition, an audit was conducted of all resident rooms to remove any signage that might communicate confidential information in a manner that was not respectful of the resident's right to privacy. This audit will be conducted again in February as a follow up check to make sure that no additional signage has been placed by staff or family members. • Letters were sent to the responsible party for all long term care residents informing them of the need to remove signage that contains confidential information. • This information will also be placed in the next family newsletter that is due out the end of February as an additional reminder to family members. • Staff were informed of these changes through education sessions and printed staff educational information. • All audits and information will be reported through the Quality Council.	

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F 164	Continued From page 6 RN-A stated that the information should not have been posted in a location where persons not privileged to the information could view it. RN-A further stated the sign was also no longer accurate and discarded it. R78 was observed in her room on 12/17/14, at approximately 2:00 p.m. Above the resident's bed was handwritten sign on pink paper with the confidential information as follows: "[R78] has film over the bottom of her right lens on her glasses. Please be careful when cleaning them it will fall off and then she can't see out of them. Thanks." On the adjacent wall at the head of R78's bed was a green, printed sign which read: "Before offering fluids check with the nurse (nectar) [indicating altered consistency of fluids were required]." On R78's free standing closet were two signs attached. The first was on a pink piece of paper. It directed staff as follows: "Do not leave [resident' room number] outside alone-- thanks." The second sign was typed on orange paper and read, "[R78] to have small pieces of chocolate with supervision. Please cut into dime size pieces or smaller even small miniature pieces should be cut into pieces." It was dated 12/16/13, with unidentified initials. As of 12/18/14, at 10:30 a.m. the signs remained unchanged on the walls and the closet. R78's quarterly Minimum Data Set (MDS) dated 10/15/14, noted the resident had dementia with severe cognitive impairment and required extensive assistance with bed mobility, transferring, dressing, personal hygiene and toileting.	F 164		

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F 164	Continued From page 7 On 12/19/14, at 3:20 p.m. the director of nursing stated she did not agree with the above findings regarding the residents' right to confidentiality. When informed residents rights could not be waived, the director stated it had always been acceptable in the past for a family member to override a resident's right to confidentiality if that was their wish. A facility 2/13 policy Quality of Life--Dignity which directed staff to "Maintain an environment in which confidential clinical information is protected, for example (b) signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room unless specifically requested by the resident or family member. Discreet posting of important clinical information for safety reasons is permissible (e.g. taped to the inside of the closet door)." A 6/09 facility policy Notice of Privacy Practices, indicated it was the facility's responsibility to "Maintain the privacy of your health information."	F 164		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

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

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F 279	Continued From page 8 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive plan of care related to a sleep medication for 1 of 5 residents (R240) who were reviewed for unnecessary medication use. Findings include: R240 was prescribed Trazodone (antidepressant medication commonly used to promote sleep) for insomnia, however, the resident's care plan did not reflect the use of the medication, nor was direction provided for staff regarding non-pharmacological interventions for insomnia. R240 was admitted to the facility in 6/14, with diagnoses including depression and insomnia. The quarterly admission Minimum Data Set (MDS) dated 9/24/14, indicated R240 was feeling down, depressed or hopeless and had trouble falling or staying asleep, however, but no behavioral issues were noted. The physician orders included Trazodone 50 milligrams (mg) to be given at bedtime for insomnia. A consultant pharmacist's review dated 8/5/14, recommended the facility clinically monitored the	F 279	F279 In order to comply with the regulation for F279 (comprehensive plan of care to include psychological recommendations) St. Gertrude's has made the following changes: a. Resident R240 and R 149 have care plan notations referring staff to the psychological recommendations that are located in the chart as well as the nursing assistant charting book on the unit. b. Social workers have assured that the resident's that have seen the psychologist previously have that indicated in the plan of care. c. Social Workers have copied all previous resident psychological recommendations for the nursing assistant charting book on each unit.	1/28/15

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F 279	Continued From page 9 use of Trazadone by conducting a sleep study at baseline (usually prior to initiating the medication), and then quarterly, with a focus on the care plan of non-pharmacological interventions to assist with sleep. Dictation regarding the use of the hypnotic was also to be included in a quarterly behavior management note. Care plan interventions, however, were not developed that addressed the residents insomnia or included non-pharmacological interventions. On 12/18/14, at 8:36 a.m. a registered nurse (RN)-D was interviewed and reported R240 was prescribed Celexa and Trazodone to treat depression. She was unaware the Trazodone was being used for insomnia as indicated on the order and pharmacy review, and verified the resident's sleep was not being monitored, nor had an insomnia care plan been developed. A 12/12 facility Care Planning Process policy indicated care plans would be "Developed within 7 days after the completion of a comprehensive assessment...The facility is responsible for addressing the resident's needs from the moment of admission."	F 279	d. Social Workers have educated the interdisciplinary team about the location of the psychological recommendations through the staff newsletter. Nurses have been updated through their communication book. Nurses and nursing assistants will be signing off on an Education form that they understand where the psychological recommendations are located. e. Social Workers have created a systematic change where each new psychology referral will be followed by the social worker placing a notation in the plan of care and copying recommendations for the nursing assistant book. f. An audit will be conducted of all psychological referrals beginning in January and conducted on a monthly basis for three months. Audit results and actions taken will be reported through the Quality Council.	
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	F 282		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 review, the facility failed to follow behavioral care plan for 2 of 5 residents (R150) reviewed with behavioral care plans. Findings include: R150 was not provided bilateral hearing aids prior to the initiation of care according to her care plan dated 3/25/14. The care plan noted R150 displayed paranoid behavior due to documentation of dementia, delirium and anxiety. Paranoid thoughts present in the form of accusing male care givers of attacking and assaulting resident both physically and sexually when being woken to perform cares. The goal was for the resident to have improved thought processes as evidenced by decrease in frequency of confusion. "She will benefit from consistency in environment and care routine, and if possible from the same staff member." The approaches directed staff to "Always ensure resident's hearing aids are placed before approaching resident when waking her from sleep. If agitated, provide calming and soothing reassurance to resident. Assist resident by re-orientating her to location and time, explain who is assisting and why." On 12/18/14, at 7:32 a.m. R150 was observed after cares had been partially completed. She was seated on the toilet and was partially dressed. R150 told NA-E and NA-D, "My skin is so dry." NA-E proceeded to apply lotion to R150's upper body. The surveyor attempted to inform the resident of the purpose of her presence. R150 responded, "I just can't hear you. Where are my hearing aids?" NA-E explained the nurse had the residents hearing aids, and she then left the room. NA-E returned	F 282	F282 In order to comply with the regulation that St. Gertrude's must provide services in accordance with each resident's written plan of care as it relates to hearing aids, St Gertrude's has done the following: • For R150, a nursing order was placed in the treatment section of the eMar to direct staff to place the hearing aids for this resident prior to the initiation of cares. Her plan of care was updated to reflect this requirement. • Staff were informed of this requirement through education sessions and printed educational information. • An audit for compliance with this requirement will be conducted every week times 3 weeks to check on staff compliance. • In addition, an audit will be conducted to determine if there are any additional residents that have a hearing aid and require them to be in prior to the initiation of cares. If any are discovered the eMar and plan of care will be updated to address it. • All audits and information will be reported through the Quality Council.	1/20/2015

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	245610	A. BUILDING _____ B. WING _____	12/19/2014

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F 282	Continued From page 11 with the aids and placed them in R150's ears, and the NAs resumed proceeding with morning cares. NA-E stated "Normally the nurse puts hearing aids in or we can go them from the nurse." R150's quarterly Minimum Data Set (MDS) dated 9/12/14, identified the resident had dementia with severe cognitive impairment, moderate hearing difficulty with hearing aid use, and an impairment in her ability to understand others, but responded adequately to simple direct communication. Additionally, the MDS described R150 as being requiring extensive assistance with bed mobility, transferring, dressing, personal hygiene and toileting. NA-E stated on 12/18/14, at 9:30 a.m. R150 will sometimes got upset when she talked to her and she did not hear what was said. NA-E reported to the nurse when the resident became upset, and reapproach the resident with the nurse. NA-C consistently worked with R150, and reported in an interview on 12/18/14, at 9:42 a.m. that when staff spoke loudly to the resident, she became upset. Even with the use of hearing aids, the resident had some difficulty hearing, and "You have to talk to her face to face. If you are talking behind her and not face to face, she gets mad." A registered nurse (RN)-A explained on 12/19/14, at 10:09 a.m. R150's hearing aids were removed from resident ears at night and were stored on medication cart. RN-A said the NAs were to bring the resident to the medication cart after she was up for the morning so she could have her hearing aids put into her ears.	F 282		

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F 282	Continued From page 12 R149 was observed on 12/16/14, during general observations of bed rails in resident rooms throughout the facility. When the surveyor approached the resident to explain her purpose, the resident reacted in a highly anxious manner, waiving her hands and shooing the surveyor out of the room. A record review revealed R149 reacted in a similar manner to two different psychologists. On 7/31/14, "She was not receptive at all to being interviewed. She verbalized the word 'no' and demonstrated strong body language indicating she wanted the screener to leave. Efforts to reassure her were ineffective so the attempt at interview was terminated." On 8/7/14, "I met with [R149] who was anxious, upset, tossing some newspapers on the floor, and generally not very receptive to my presence. This is probably what was described to me by staff when in the evenings she has cares provided by staff she is less familiar with from the Heath Care team." R149 was admitted to the facility in 7/14, having previously resided in an assisted living facility. A face sheet in the medical record noted diagnoses including pervasive developmental delay not otherwise specified and an adjustment disorder with anxiety. A NAR [NA/registered] Care Guide for R149 directed staff to provide care with one staff, and outlined toileting and repositioning instruction, noted the resident was at risk for falling, had a hearing aid, and was at risk for choking and bruising. In addition, staff was instructed to assist the resident to call her family weekly. R149's care plan dated 8/13/14, noted the resident had anxiety and displayed occasional	F 282		

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F 282	Continued From page 13 refusal of cares. Approaches were to administer antidepressant medication, monitor mood and behaviors/update the physician, allow time to finish statements, preferred female caregivers, reapproach with caregiver she knows/trusts for communication, eliminate background noise, speak slowly in clear distinct voice and allow time to respond, use hand gestures or other form of communication if needed. Generic care plan approaches dated 8/7/14, for cognitive loss and mood/behavior difficulty directed staff to approach from the front, make eye contact, speak directly, address by preferred name, redirect to topics of interest, 1:1 and offer support and reassurance, approach in calm manner at arms length speaking in calm tone, , allow to express feelings, answer questions, redirect to cal environment, invite to activities as needed, refer to psychologist as needed (noted was seen 8/7/14). NA-F was interviewed regarding R149 on 12/18/14, at approximately 2:15 p.m. says she usually worked as a primary aide on the 400 wing, but they needed help on (R149's wing) so she was "down here helping out." She was not specifically assigned to care for R149 that day. NA-C reported on 12/18/14, at approximately 2:30 p.m. that she was R149's primary aide. NA-C was asked how she learned to care for R149. She said the NAs were not provided written instructions, rather, she just "figured it out on her own." She found the resident responded best when approached very calmly, and when the caregiver did not talk much during the provision of care. She explained that R149 was "much better now" than when first admitted, and NA-C thought it was a problem with adjustment to the facility. She said the resident's preferences included	F 282		

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F 282	Continued From page 14 reading the paper, watching the birds, and walking. NA-B was interviewed on 12/19/14, at 9:28 a.m. said that although she was working on R149's wing that day, she usually worked as a primary aide on the 400 wing. She said NAs were not provided with any written instruction regarding how to care for a resident except for what was in the behavior book. Upon looking in the book, NA-B confirmed the section under R149's room was blank and no information was provided. NA-B said she knows her residents because after awhile you "get used to them." Regarding resident care preferences, she added that the NAs "figure it out on their own." NA-B said that prior to caring for a new resident, the NAs had to ask the nurse what they were supposed to do for the resident, and then "they would have to write it down for me." NA-A was interviewed on 12/19/14, at 11:30 a.m. She reported she was an on call staff who was assigned to R149 that day. When asked how she learned an individual resident's needs and preferences she replied, "That's a very good question. From years of experience, you learn how to treat people...It's obviously not my first rodeo." She said she had cared for R149 before, and she easily became anxious with new people as evidenced by waiving her hands. NA-A said what she found to be an effective, was to approach R149 slowly while rubbing her shoulder and reassuring her she was "okay." If NA-A had questions about a resident, she "asked other staff." NA-A said there was information in the computer related to each residents' specific care, but this information did not also include preferences aside from the resident's desire to	F 282		

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F 282	Continued From page 15 keep in touch with her family. A registered nurse (RN)-B was interviewed on 12/19/14 at 11:52 a.m. She explained there was a care guide for the NAs to follow. She showed the surveyor a description as noted above. RN-B explained there was also a Kardex the NAs could reference. The Kardex had check marks for activities of daily living, however, there was no information regarding measures to use to minimize the resident's anxiety, or her preferences. When asked how the NAs know resident pretences, and for example, how to approach R149 related to her special needs. RN-B said the NAs could ask the nurse. In addition, RN-B explained that "Sometimes she doesn't want me in there, and then we try again later. Or maybe say so and so cared for her yesterday, let's try that. We try to have familiar aides work with her." A 12/12 facility Care Planning Process policy noted care plans were for the purpose of "the highest level of functioning the resident may expect to attain, based on the comprehensive assessment."	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the use of side rails were deemed to be safe for each individual, and to ensure the rails met Federal Drug Administration (FDA) Zone requirements for 7 of 90 residents (R167, R69, R183, R187, R383, R387, R384) whose beds included bed rails. Findings include: R167 was observed in bed on 12/6/14, at 2:02 p.m. Bilateral half side rails with visible large gaps between the rails and the mattress. Each rail had four sections, two sections measured 7 1/4 inches by 7 3/4 inches in Zone 1. The annual Minimum Data Set (MDS) dated 10/11/14, identified R167 as having a diagnoses including dementia, depression, and anxiety. It was also noted the resident was severely cognitively impaired, required extensive assistance with bed mobility, transferring, dressing, personal hygiene, toileting and had experienced one fall without injury since the previous assessment. A side rail assessment dated 11/4/13, identified a device was used which was upper half rail with built in bed controls. The reason for use was as a mobility aid (assist with turning side to side or sitting up) and to assist with transfers. The device was identified as not a restraint. The assessment was reviewed on 4/26/14 and 7/21/14. The care plan, undated indicated upper rails with bed controls. The goal stated "will preserve ability to use device or increase ability for bed	F 323	F 323 In order to comply with the regulation that St. Gertrude's must ensure that the resident environment remains as free of accident hazards as is possible as it relates to side rail safety, we have done the following: • On 12/17/14, the concern with the side rails not meeting the FDA guidelines for safety was raised with the facility staff. At that point, Plant Op accompanied the surveyor and measured the gap within the side rails (Zone 1) on specified beds and found the gap to exceed 4 ¾ inches on those beds (R167, R69, R183, R187, R383, R387, R384). Following this, Plant Op. immediately proceeded with the Nurse Managers & DON to reassess the residents in these beds, secure the side rails under the bed (to prevent use and ensure safety), and instruct both the resident and the staff that these changes were made and that the staff were to be called if the resident needed any assistance with bed controls or repositioning. The residents' care plans were updated to reflect these changes.	1/28/15

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F 323	Continued From page 17 mobility (he participates with repositioning)." The approaches indicated to encourage to grab upper half side rails or grab bars when turning or sitting up in bed. The care plan dated 11/21/13, identified R167 as at risk for falls related to weakness, history of falls, unsteadiness, needing extensive staff assistance for mobility, history of dementia and incontinence. The approaches directed staff to transfer with the EZ lift (full body lift machine) with 2-3 staff assistance (updated 12/3/14). During interview on 12/16/14, at 9:41 a.m. a registered nurse (RN)-A stated R167 had two half side rails up on bed with bed controls, for turning and repositioning. RN-A also stated R167 had experienced a fall on 12/3/14, due to syncope (sudden loss of consciousness) during a transfer with the mechanical standing lift and went down onto the floor during the transfer. R69's bed was observed on 12/6/14, at 10:44 a.m. with bilateral half side rails with large gaps was observed on the bed. Each rail had four sections, two sections measured 7 1/4 inches by 7 3/4 inches in Zone 1. The quarterly MDS dated 9/16/14, identified R69 as being cognitively intact, and required extensive assistance with bed mobility, transferring, dressing, personal hygiene and toileting, and was unable to walk. R69's side rail assessment dated 12/19/12, identified device used; upper half rail with bed controls built in and reason for use; bed mobility aid and bed controls use by resident for bed adjustments. The assessment was reviewed on	F 323	• Following this, an audit was completed on all beds in the facility and if any side rail were found to be out of compliance, it was handled as stated previously. • The next morning, 12/17/14, Posey Elastic Mesh Side Rail covers were ordered for all of the affected beds. They arrived by the afternoon of 12/18/14 and Plant Op worked with the nursing staff to have the residents reassessed and to install these covers on the side rails that were out of compliance with the FDA guidelines. • The Hill Rom Company (manufacturer of the beds that were out of side rail compliance) was contacted for a permanent fix to the side rails and the kit for each bed was ordered. The arrival of these parts is dependent on the company's production and will be installed after receipt. • Nursing will continue to conduct side rail use assessments. These assessments will not contain the safety measurements conducted by Plant Op.	

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F 323	Continued From page 18 10/14/13, 1/4/14, and 6/23/14. The care plan dated 12/19/12, indicated upper rails with bed controls. The goal stated will preserve ability to use device or increasing ability for bed mobility, preserve ability to use device for transfers and ability to use controls for bed adjustments. Approaches indicated to encourage to grab upper half side rails or grab bars when turning or sitting up in bed. During interview on 12/16/14, at 9:58 a.m. RN-A stated R69 had two half side rails up on bed with bed controls, for turning and repositioning. R183's bed was observed on 12/15/14, at 7:31 p.m. R183 was in bed with bilateral half side rails up on both sides of the bed. On 12/16/14, at 10:44 am. bilateral half side rails with large gaps was observed on R183's bed. Each rail had four sections, two sections measured 7 1/4 inches by 7 3/4 inches in Zone 1. R183's annual MDS dated 9/15/14, identified R183 as having a diagnosis of arthritis, osteoporosis, and vision impairment, and the resident had moderate cognitive impairment, requiring extensive assistance with bed mobility, transferring, dressing, personal hygiene and toileting and limited assistance with walking. The side rail assessment dated 12/15/14, identified device used; upper half rail with bed controls built in and reason for use; bed mobility aid, assist with transfers and bed controls used by resident for bed adjustments. It was noted the device was not a restraint.	F 323	• To avoid this situation going forward, any rental bed that comes into the facility will have a statement from the supplier that the side rails will meet the FDA guidelines. In addition, Plant Op will check these beds for compliance. Any new bed that is purchased by the facility will be checked by Plant Op for compliance. • Nursing Staff were educated on the above through education sessions and printed educational information. • Plant Op will conduct an annual audit of the compliance to the zones listed in the FDA guidelines. All of this will be documented & maintained by Plant Operations. • Results of audits and any actions taken will be reported to the Quality Council	

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F 323	Continued From page 19 R183's undated care plan indicated upper rails with bed controls. The goal stated "will preserve ability to use device or increase ability for bed mobility and preserve ability to use controls bed adjustments." Approaches indicated to encourage to grab upper half side rails or grab bars when turning or sitting up in bed. During an interview on 12/16/14, at 9:53 a.m. RN-A stated R183 had two half side rails up on bed with bed controls, for turning and repositioning and is independent with mobility in her room. RN-A further indicated resident had a fall on 11/20/14, when she slid out of her wheelchair reaching for something on her table in her room. During an interview on 12/16/14, at 3:35 p.m. with RN-A explained the facility had multiple (10 or more) different types of side rails in use. RN-A indicated the facility had some low beds with grab bars and some bed beds with 1/2 side rails, both had cords with attached controls with head and foot controls and some leased beds had controls in the side rails. RN-A stated residents were assessed and need to demonstrate that they were able to turn in bed or participate in turning in bed. The side rail use was reviewed quarterly. RN-A further stated sometimes it was just the bed that was in the room, and facility assessed whether "it works, and then go with it." R187's bed was observed on 12/16/14 at 1:37 p.m. The bed had bilateral half side rails with large gaps. Each rail had four sections, two sections measured 7 1/4 inches by 7 3/4 inches in Zone 1. The 30 day MDS dated 11/5/14, identified R187	F 323		

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F 323	Continued From page 20 as requiring extensive assistance with transfers and bed mobility. The side rail assessment dated 10/8/14, identified the device was used for bed mobility aid to assist with transfers, bed controls were used by the resident for bed adjustments. On 12/17/14 it was updated and indicated no device was being used. The care plan for side rails and grab bars dated 10/8/14 identified the device as upper half with bed controls. The goal was to preserve ability to use device for bed mobility, will preserve ability to use device for transfers and will preserve ability to use controls for bed adjustments. On 12/17/14 the facility discontinued the use of the side rails and care plan. R383's bed was observed on 12/16/14, at 1:36 p.m. The bed had bilateral half side rails with large gaps. Each rail had four sections, two sections measured 7 1/4 inches by 7 3/4 inches in Zone 1. R383 had diagnoses including chronic airway obstruction and muscle weakness. The MDS dated 12/9/14 was in the process of completion and noted the resident required extensive assist with mobility and self-performance. The side rail assessment dated 12/2/14, identified the device was used for bed mobility aid and to assist with transfers, bed controls used by the resident for bed adjustments. It was revised on 12/17/14 indicated no device was being used. R387's bed was observed on 12/16/14, at 1:32 p.m. The bed had bilateral half side rails with large gaps. Each rail had four sections, two	F 323		

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F 323	Continued From page 21 sections measured 7 1/4 inches by 7 3/4 inches in Zone 1. R387 had a diagnoses including a history of falls, malaise and fatigue, and failure to thrive. The resident required assistance with transfers. The side rail assessment dated 12/8/14, identified the device was used for bed mobility aid, to assist with transfers, and bed controls used by the resident for bed adjustments. On 12/17/14 it was updated indicated no device was used. The care plan for side rails and grab bars identified the device as upper half with bed controls. The goal was to preserve ability to use device for bed mobility, preserve ability to use device for transfers and ability to use controls for bed adjustments. On 12/17/14 the facility discontinued the use of the side rails and care plan R384's bed was observed on 12/16/14, at 3:20 p.m. The bed had half side rails up on both sides of the bed. Each side rail had four sections, and the rails had large enough gaps in the center two sections that surveyors questioned whether they exceeded the Zone 1 dimension requirements. The center two sections' gaps were observed to be measured as follows by Plant Operations staff. The dimension of the upper [nearer to the head of the bed] central gap was 7 1/8 inches wide by 7 5/8 inches tall. The lower [nearer to the foot of the bed] gap was 7 inches wide by 7 5/8 inches tall. R384 had diagnoses that included surgical aftercare following a femoral popliteal iliac	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

(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 323	Continued From page 22 endarterectomy (a surgical procedure that removed or decreased blockage of blood flow to the leg). R384's side rail assessment dated 12/5/14, included device used as upper half rail with bed controls, and the reasons were for bed mobility and assist with transfers. The care plan dated 12/5/14, included that R384 was at high risk for falls. The care plan for Side Rails/Grab Bars dated 12/5/14 included the same information as the assessment. None of the information included am assessment of whether R384 would have been safe to be in a bed with the specific (large Zone 1 gap) rails observed. In an interview during an environmental tour to inspect bed rails on 12/17/14, at 9:27 a.m. the Chief of Plant Operations indicated he had seen the Care Providers fit kit (a kit that tested side rails for dimensions of gaps that could affect resident safety), but had "not used it on our beds." The director of nursing added on 12/17/14, at 9:33 a.m. "We just purchased these 20 Hill-ROM beds [equipped with the side rails in question] in the last few years from St Francis [associated hospital] and we will be having a conversation with them about how the beds they sold us did not meet safety standards." On 12/17/14 the facility discontinued the use of the side rails for and updated the care plan to reflect that. On 12/17/14, at 2:19 p.m. observation verified that R384's bed had all four bed rails lowered beneath bed frame level, and had been secured	F 323		

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F 323	Continued From page 23 in that position with Zip-ties to each rail such that the rail could no longer be raised; this was in accord with what the DON had told surveyors that morning would be done to remedy the situation.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	F356 In order to comply with the regulation that St. Gertrude's must post the nurse staffing data in a clear and readable format and in a prominent place readily accessible to residents and visitors, we have done the following: • The posting form was immediately lowered to wheelchair height. • The form was reformatted to make the print larger and easier to read. • The carts were removed from the area and this is being audited at least weekly for 1 month for compliance. • Staff were informed of this requirement through education sessions and printed educational information. • All results will be reported through the Quality Council.	1/20/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 356	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post daily nurse staffing information in a manner easily visible to residents and visitors. This had the potential to affect all 90 residents currently residing in the facility, as well as any family members or visitors. Findings include: During the initial facility tour on 12/19/14, at 10:21 a.m. the nurse staff posting was located on a bulletin board between the 300 and 400 units. The posting was printed on an 8 1/2 by 11 sheet of paper and was approximately six feet in height. Three rolling carts were stored in front of the bulletin board, blocking access to the area. The information remained posted in the manner described above with two to three carts in front of the posting on 12/16/14, at 9:00 a.m.; 12/17/14, at 12:00 p.m.; 12/18/14, at 10:20 a.m.; and 12/19/14, at 10:00 a.m. When interviewed on 12/19/14, a registered nurse (RN)-C stated the day shift charge nurse was responsible for recording the daily nursing staffing information, and placing it on the board. She stated that because the information was posted so high and the carts were stored in front of the board, residents and residents and visitors would probably not have been able to read the posted information. The facility's 3/13 Posting of Staffing Hours policy addressed how to fill in the information on the posting, but did not address how or where the information would be posted.	F 356		

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F 431 F 431 SS=D	Continued From page 25 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431 F 431	F431 In order to comply with the regulation that St. Gertrude's must ensure that expired medications are not stored for use, we have done the following: • The expired insulin for resident (R134) was discarded and immediately reordered. • All med. carts and refrigerators were audited to assure that there were no other expired medications that same day. • Staff were informed of this requirement through education sessions and printed educational information. • To avoid a recurrence of this situation, the medications that require "date opened" labelling in the med cart and refrigerator will be audited weekly for one month and then monthly thereafter for any expired medications. • All audit results will be reported through the Quality Council.	1/20/2015

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F 431	Continued From page 26 Based on observation, interview and document review, the facility failed to ensure an insulin vial did not remain in use for 1 of 1 (R134) whose insulin had been stored for use beyond its expiration date. Findings include: On 12/15/14, at 3:29 p.m. an observation of the facility's medication storage on the 400 wing was conducted. A vial of NovoLog insulin was found on the medication cart labeled with R134's name, and included a hand-written opened date of 11/11/14. A licensed practical nurse (LPN)-E verified at the time the date on the vial read 11/11/14. During an interview on 12/15/14, at 3:29 p.m. LPN-E stated she thought the insulin vial should have been discarded on 12/11/14 (which would have been 30 days). Shortly afterward, a registered nurse (RN)-A reported she thought an insulin vial should have been good for 30 days after being opened. She then added she thought the expiration date on R134's vial was possibly smudged and might have read 11/17/14. R134's medical record face sheet inlcuded a diagnosis of diabetes mellitus, for which NovoLog was used to treat. The resident's Medication Administration Record (MAR) revealed the vial dated 11/11/14, had been used to administer at least 18 doses of Novolog between 12/9/14 (the first day the vial was expired) and 12/15/14, at 3:29 p.m. when the expired vial was discovered by the surveyor. On 12/15/14, at.4:37 p.m. RN-A indicated if the label had been unclear, the nurses should have	F 431		

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F 431	Continued From page 27 assumed the open date was the earliest it could have possibly been and should have been discarded in relation to that date. She said two nurses had checked it the day before during a weekly check, and thought it may have read 11/17/14. She added that each time they gave a medication they need to be checking the label to see that it was not expired. She indicated there was an unopened vial for R134 in the medication refrigerator, and that she had discarded the out-of-date vial and replaced it with the new vial.	F 431		

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PRINTED: 01/05/2015
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245610	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/18/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Gertrudes Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok TB 1-23-15 RECEIVED JAN 20 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 12-19-14 DC: 1-28-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rick Meyer	Administrator	1-16-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 By email to: Marlan.Whitney@state.mn.us and 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. This facility will be surveyed as three separate buildings. St. Gertrudes Health Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1996 and was determined to be of Type V (111) construction. In 1999, an addition was constructed to the East Wing that was determined to be of Type V(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in resident room, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 105 beds and had a census of 90 at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
K 054 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Chapters 19.3.4.1, 9.6.1.4, 1999 NFPA 72, Section 7-3.2.1. The deficient practice could affect all 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, the review of the annual fire alarm inspection and testing report from MN Conway, dated 11/24/2014, indicated that the count of devices and devices tested did not equal each other. This deficient practice was confirmed by the Plant Operations (TL) at the time of discovery.	K 054	K 54 Contracted Fire Alarm Company will be directed to re-do their work on the Annual Sensitivity Testing as their most recent testing was incomplete. Plant Manager will review all future testing reports for accuracy. The two identified smoke detector heads that are too close to the diffusers will be relocated.	Jan 23, 2015
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		

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K 062	Continued From page 3 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7, as well as 1998 NFPA 25, sections 2-2.1.1 and 2-4.1.4. This deficient practice could affect 20 out of 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, observation revealed that the following was found: 1. The spare sprinkler head box - does not contain (2) spare sprinkler heads of each type 2. In the kitchen - dish washing area, there are serveral sprinkler heads that are corroded These deficient practices were confirmed by the Plant Operations (TL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	K 62 Contracted Fire Sprinkler Company will replace the corroded Fire Sprinkler heads in kitchen dishwashing area and pool mechanical room. Additional Fire Sprinkler heads will be purchased to ensure that there are 2 of each type in the spare sprinkler head boxes. Plant Manager will monitor boxes for compliance during quarterly inspections.	Jan 23, 2015

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PRINTED: 01/05/2015
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245610	A. BUILDING 02 - 2008 & 2011 ADDITION B. WING _____	12/18/2014

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rich Meyer
TITLE: Administrator
(X6) DATE: 1-16-15

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 By email to: Marian.Whitney@state.mn.us and 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. This facility will be surveyed as three separate buildings. St. Gertrudes Health Center, 2007 addition is a 1-story building with no basement. In 2007, an addition was constructed and was determined to be of Type V(111) construction. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in resident room, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 105 beds and had a census of 95 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 054		

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K 054	Continued From page 2 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Chapters 18.3.4.1, 9.6.1.4, 1999 NFPA 72, Section 7-3.2.1. The deficient practice could affect all 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, the review of the annual fire alarm inspection and testing report from MN Conway, dated 11/24/2014, indicated that the count of devices and devices tested did not equal each other. This deficient practice was confirmed by the Plant Operations (TL) at the time of discovery.	K 054	K 54 Contracted Fire Alarm Company will be directed to re-do their work on the Annual Sensitivity Testing as their most recent testing was incomplete. Plant Manager will review all future testing reports for accuracy. The two identified smoke detector heads that are too close to the diffusers will be relocated.	Jan 23, 2015
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 062		

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	245610	A. BUILDING 02 - 2008 & 2011 ADDITION B. WING _____	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062	Continued From page 3 facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.5 and 9.7, as well as 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect 20 out of 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, observation revealed that the spare sprinkler head box - does not contain (2) spare sprinkler heads of each type. This deficient practice was confirmed by the Plant Operations (TL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	K 62 Contracted Fire Sprinkler Company will replace the corroded Fire Sprinkler heads in kitchen dishwashing area and pool mechanical room. Additional Fire Sprinkler heads will be purchased to ensure that there are 2 of each type in the spare sprinkler head boxes. Plant Manager will monitor boxes for compliance during quarterly inspections.	Jan 23, 2015

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

PRINTED: 01/05/2015
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
	245610	A. BUILDING 03 - BLDG THREE NEW ADDITION B. WING _____	12/18/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Gertrudes Health Center 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok RB 1-23-15 RECEIVED JAN 20 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rich Meyer — TITLE: Administrator — (X6) DATE: 1-16-15

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.

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

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	245610	A. BUILDING 03 - BLDG THREE NEW ADDITION B. WING _____	12/18/2014

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K 000	Continued From page 1 By email to: Marlan.Whitney@state.mn.us and 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. This facility will be surveyed as three separate buildings. St. Gertrudes Health Center, 2011 addition is a 2-story building with a basement. In 2011, an addition was constructed and was determined to be of Type II(222) construction. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in resident room, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 105 beds and had a census of 95 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING 03 - BLDG THREE NEW ADDITION B. WING _____	12/18/2014

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K 033	Continued From page 2 Exit components (such as stairways) in buildings four stories or more are enclosed with construction having fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a fire resistance rating of at least one hour in the exit component accordance with the following requirements of 2000 NFPA 101, Section 18.3.1.1, 8.2.5.2. The deficient practice could affect 25 out of 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, observation revealed that in the East Stairwell on 3rd floor , above the lay in ceiling, there is an open penetration around conduit. NOTE: Check all stairwells and floors. This deficient practice was confirmed by the Plant Operations (TL) at the time of discovery.	K 033	K 33 The open penetration in the stairwell above the ceiling will be caulked per code. Plant Manager will monitor these compartments whenever a contractor completes work in those areas.	Jan 23, 2015

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K 052	Continued From page 3	K 052		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72 Section 3-9.4.4. This could effect all 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, testing of the control circuits to shut down elevator power shall be monitored for presence of operating voltage. The loss of voltage to the control circuit for the disconnecting means did not cause a supervisory signal to be indicated at the control unit and required remote annunciators. This deficient practice was confirmed by the Plant Operations (TL) at the time of discovery.	K 052	K 52 Contracted Fire Alarm Company and Contracted Electrician will install the necessary equipment/wiring to connect the elevator Shut Trip power loss notification to the Fire Annunciator panel.	Jan 23, 2015
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved,	K 054		

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K 054	Continued From page 4 maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation, documentation review and staff interview, the facility failed install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Chapters 18.3.4.1, 9.6.1.4, 1999 NFPA 72, Section 2-3.5.1 and Chapter 7. The deficient practice could affect all 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, revealed that the following was found: 1. The smokes detectors in rooms # 1009-2 and 2009-2, are located closer than 3 feet from supply or return vents; 2. The review of the annual fire alarm inspection and testing report from MN Conway, dated 11/24/2014, indicated that the count of devices and devices tested did not equal each other These deficient practices were confirmed by the Plant Operations (TL) at the time of discovery.	K 054	K 54 Contracted Fire Alarm Company will be directed to re-do their work on the Annual Sensitivity Testing as their most recent testing was incomplete. Plant Manager will review all future testing reports for accuracy. The two identified smoke detector heads that are too close to the diffusers will be relocated.	Jan 23, 2015
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide	K 056		

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K 056	Continued From page 5 complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 13. This deficient practice could affect 10 out of 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, observation revealed that the lower level physical therapy storage room pendant concealed sprinkler head was located 3 feet from ceiling. This will reduce the activation time of the fire sprinkler head. This deficient practice was confirmed by the Plant Operations (TL) at the time of discovery.	K 056	K 56 Contracted Fire Sprinkler Company will relocate the identified fire sprinkler on storage room to meet code.	Jan 23, 2015
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		

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K 062	Continued From page 6 continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 . NFPA 101, Sections 18.3.5 and 9.7, as well as 1998 NFPA 25, sections 2-2.1.1 and 2-4.1.4. This deficient practice could affect 20 out of 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, observation revealed that the following was found: 1. The spare sprinkler head box - does not contain (2) spare sprinkler heads of each type 2. In the pool mechanical room # L106-3, there are several sprinkler heads that are corroded These deficient practices were confirmed by the Plant Operations (TL) at the time of discovery.	K 062	K 62 Contracted Fire Sprinkler Company will replace the corroded Fire Sprinkler heads in kitchen dishwashing area and pool mechanical room: Additional Fire Sprinkler heads will be purchased to ensure that there are 2 of each type in the spare sprinkler head boxes. Plant Manager will monitor boxes for compliance during quarterly inspections.	Jan 23, 2015
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical system in accordance with the requirements of 2000 NFPA 101 Chapter 18.5.1.1, 9.1.2, and 1999 NFPA 70. The deficient practice could affect 20 out of 90 residents. Findings include: On facility tour between 7:45 AM and 11:30 AM on 12/18/2014, observation revealed that the following was found: 1. In the pool mechanical room # L106-3, that all conduit, outlets, light switch boxes have heavy corrosion on them. Have a licensed electrician investigate that all electrical items are to NFPA 70 electrical code; 2. Remote food serving room # 1036 - circuit breaker panel does not have proper clearance These deficient practices were confirmed by the Plant Operations (TL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	K 147 Contracted Electrician will replace corroded electrical outlet boxes and pipes in the Pool Mechanical Room with NEMA 4 equipment. Plant Manager will monitor the wiring for corrosion during quarterly inspections. Obstructions will be removed in front of the electrical panels. Plant Manager will monitor for compliance during quarterly inspections.	Jan 23, 2015