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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IXDW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00498

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245534**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CAPITOL VIEW TRANSITIONAL CARE CENTER**
(L4) **640 JACKSON STREET**
(L5) **SAINT PAUL, MN** (L6) **55101**

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 **04/11/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **04** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (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
32				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Robyn Woolley, HFE NE II — 04/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 04/17/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1989
(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
Posted 5/3/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/29/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5534

At the time of the standard survey completed February 28, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On April 11, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 28, 2013, effective April 1, 2013. Therefore, the remedies outlined in our letter dated March 14, 2013, will not be imposed. See the attached CMS-2567B form for the results of the April 11, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5534 April 17, 2013

Ms. Michelle Mangan, Administrator
Capitol View Transitional Care Center
640 Jackson Street
Saint Paul, Minnesota 55101

Dear Ms. Mangan:

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 Program.

Effective April 1, 2013 the above facility is certified for:

32 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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 provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 17, 2013

Ms. Michelle Mangan, Administrator
Capitol View Transitional Care Center
640 Jackson Street
Saint Paul, Minnesota 55101

RE: Project Number S5534023

Dear Ms. Mangan:

On March 14, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 28, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 11, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 28, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 1, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 28, 2013, effective April 1, 2013 and therefore remedies outlined in our letter to you dated March 14, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

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

Enclosure

cc: Licensing and Certification File 5534r113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245534	A. Building B. Wing	4/11/2013

Name of Facility	Street Address, City, State, Zip Code
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

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 **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **04/01/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/01/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/01/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/01/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/01/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/sd	04/17/13	20810	04/11/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/28/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IXDW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00498

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245534**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CAPITOL VIEW TRANSITIONAL CARE CENTER**
(L4) **640 JACKSON STREET**
(L5) **SAINT PAUL, MN** (L6) **55101**

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 **02/28/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (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
32				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE NE II 03/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/28/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1989
(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
Posted 3/29/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN# 24-5534

At the time of the standard survey completed February 28, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.

Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3927

March 14, 2013

Ms. Michelle Mangan, Administrator
Capitol View Transitional Care Center
640 Jackson Street
Saint Paul, Minnesota 55101

RE: Project Number S5534023

Dear Ms. Mangan:

On February 28, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>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:

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

Telephone: (651) 201-3793

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 April 9, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 28, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 28, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

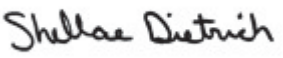
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



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

Enclosure

cc: Licensing and Certification File 5534s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	The submission of this plan of correction does not constitute admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for 1 of 30 residents (R230) in the sample. Findings include: Resident (R230)'s call light was observed to be out of reach on 02/25/13 and 02/26/13. R230 was admitted on 02/17/13 for rehabilitation and clinical monitoring post hospitalization for	F 246 3/27/13 SER	Capitol View Transitional Care Center provides services that accommodate each patient's individual needs and preferences. These services include making sure that each patient's call-light is within reach. A. Patient R230 has discharged. The surveyor did state that she checked this patient's and other patients' call-lights and they were in reach during the remainder of the survey. B. NAR- A has been re-educated on the importance of making sure the call light is within the patient's reach. All staff have been retrained on the importance of assuring that patients receive services in the facility with reasonable accommodation of individual needs and preferences such as, but not excluded to: call-light within reach. C. The interdisciplinary team has been directed to watch for improvement with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other patients would be endangered. An audit tool will be implemented to assure compliance. D. The Administrator or designee remains responsible.	4/1/2013

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Mangan — TITLE: Administrator — (X6) DATE: 3/21/13

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 246	Continued From page 1 stroke with right-sided weakness. Review of Temporary Care Plan, dated 02/17/13, indicated R230 needed extensive assistance of two staff members for bed mobility, transfers, mobility and was receiving physical and occupational therapies. In addition, R230 required assistance of one staff with dressing, grooming, toileting, bathing, and eating. On 2/25/13, at 6:07 p.m. R230 was waving for surveyor to enter his room. Upon entry he indicated he wanted to get into his bed. R230 was sitting in his wheelchair next to his bed with his over the bed table in front of him. His call light was on the bed however, the R230 could not reach it. During observations on 02/26/13 at 8:33 a.m. R230 was sitting in the wheelchair at his bed side with right arm in a sling and his call light was placed out of reach on the far side of his bed. R230 made a hand gesture with his left hand for the surveyor to enter his room and pointed towards his bed and requested to lie down. Surveyor asked if R230 could reach his call light and he stated "no." Nursing assistant (NA)-A entered room with a breakfast meal tray, NA-A stated it was time to eat and started feeding R230. During an interview with NA-A on 02/26/13 at 10:36 a.m. regarding R230's call light was not within reach, he indicated that he, "didn't realize that it wasn't within reach and it should be within reach." During an interview with the administrator on	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 246	Continued From page 2 02/27/13 at 11:27 a.m., she stated all staff members were trained to make sure when residents are in their rooms that their call lights are within reach and provided a copy of the facility policy regarding call lights needed to be within reach. The facility policy titled, "PCO7-Answering the Call Light", revised in February 2013, revealed, "When the patient is in bed or confined to a chair be sure the call light is within easy reach of the patient."	F 246		
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 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	F 279	Capitol View Transitional Care Center will continue to develop a comprehensive care plan for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. A. Patient R11 care plan addresses her sleep medication. B. All licensed staff will be retrained on the requirement of following the plan of care and physician orders; along with adding changes in the plan of care to reflect the patient's current condition. C. A complete interdisciplinary review will take place on a bi-weekly basis. Appropriate changes to the care plan will be instituted and communication to all nursing staff. D. The Interdisciplinary team members remain responsible.	4/1/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 279	Continued From page 3 by: Based on document review and interview, the facility did not develop a comprehensive and individualized plan of care for sleep disturbance for 1 of 4 residents (R11) in the sample reviewed for sleep medication use. Findings include: Record review revealed R11 was admitted to the facility 12/13/12 for rehabilitation following spinal surgery. The Physician Order Report contained an order, dated 1/7/13, for trazodone (an anti-depressant also used for sleep) 25-50 mg. at bedtime as needed for sleep and anxiety. The Medications Administration History showed that the resident received this medication nearly every night since 1/8/13. The Temporary Care Plan and the current Care Plan, dated 1/1/13, did not contain any problem related to sleep disturbance or the use of trazodone. The record did contain Observation Report forms completed by staff every shift. This form included a generic checklist of non-pharmacological interventions that could be attempted for a resident regarding sleep. When interviewed on 2/27/13 at 2 p.m., the assistant director of nursing stated that the non-pharmacological sleep interventions checklist on the Observation Report form is the same for all residents and the use of trazodone for sleep by R11 should be included on the resident's care plan.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 4 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not provide assessment for initiation of sleep medication, monitoring of all identified target behaviors, monitoring of effectiveness of non-pharmacological interventions for sleep, and monitoring for side effects of a psychoactive medication on night shift for 1 of 4 residents (R11) in the sample reviewed for use of sleep medication. Findings include:	F 329	Capitol View Transitional Care Center patients' drug regimen continues to be free from unnecessary drugs. A. Patient R11 needed her sleep medication as documented in the patient's physician notes. Patient R11's care plan has been updated with her sleep medication. B. All licensed staff have been reeducated on the need for assessment for initiation of sleep medication, monitoring of all indentified target behaviors, monitoring of effectiveness of non-pharmacological interventions for sleep, and monitoring for side effects of a psychoactive medication on the night shift. Capitol View will also be adding additional documentation assessment for patient's receiving sleep medication. C. All patients that receive any PRN or regularly scheduled sleep medication will continue to be reviewed, at a minimum, on a monthly basis. D. The Director of Nursing or designee remain responsible.	4/1/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 5 Record review revealed R11 was admitted to the facility 12/13/12 for rehabilitation following spinal surgery. The Physician Order Report contained an order, dated 1/7/13, for trazodone (an anti-depressant also used for sleep) 25-50 mg. at bedtime as needed for sleep and anxiety. The Medications Administration History showed that the resident received this medication nearly every night since 1/8/13. No sleep assessment or sleep monitoring at the time of initiation of the trazodone was in the record. A Consent For Use Of Psych Meds form, dated 1/7/13, listed trazodone as the drug requiring consent and the target behaviors being monitored for the trazodone use were listed as restless, sleep disturbance, constant worrying, and difficulty initiating or maintaining sleep. No monitoring of the "restless" or "constant worrying" target behaviors could be located in the record. No documentation of effectiveness of non-pharmacological interventions for sleep was found in the record. Monitoring for side effects of the trazodone was documented on the Inter Disciplinary Flow Sheet for the day and evening shifts, but not the night shift. When interviewed on 3/4/13 at 3:30 p.m., the assistant director of nursing stated that there was no monitoring of sleep at the time of initiation of the trazodone. The resident complained of sleep disturbance and a physician's order was obtained. She confirmed there was no monitoring of the identified target behaviors of "restless" and "constant worrying." She acknowledged that the effectiveness of non-pharmacological sleep interventions were not documented. She also acknowledged that side effects monitoring was	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 not included on the night shift flowsheets, and stated that those forms had been changed recently and the side effects monitoring portion may have been accidentally left out of the night shift Inter Disciplinary Flow Sheet.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility's consulting pharmacist did not advise the facility of irregularities in monitoring of all identified target behaviors, monitoring for side effects of psychoactive medication, and documenting effectiveness of non-pharmacological interventions related to sleep disturbance for 1 of 4 residents (R11) in the sample reviewed for use of sleep medication. Findings include: Record review revealed R11 was admitted to the facility 12/13/12 for rehabilitation following spinal surgery. The Physician Order Report contained an order, dated 1/7/13, for trazodone (an	F 428	Capitol View Transitional Care Center patient's drug regimen is reviewed by a licensed pharmacist at a minimum of once a month and irregularities are reported to the physician and the Director of Nursing. All irregularities are acting upon if the physician agrees with the recommendation. A. Patient R11 needed her sleep medication as documented in many physician notes. Patient's R11 care plan has been updated with her sleep medication. B. All licensed staff have been reeducated on the need for assessment for initiation of sleep medication, monitoring of all indentified target behaviors, monitoring of effectiveness of non-pharmacological interventions for sleep, and monitoring for side effects of a psychoactive medication on night shift. Capitol View will also be adding additional documentation assessment for patient's receiving sleep medication. C. All patients that receive any PRN or regularly scheduled sleep medication will continue to be reviewed, at a minimum, once a month. D. The Interdisciplinary team members remain responsible	4/1/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 428	Continued From page 7 anti-depressant also used for sleep) 25-50 mg. at bedtime as needed for sleep and anxiety. The Medications Administration History showed that the resident received this medication nearly every night since 1/8/13. A Consent For Use Of Psych Meds form, dated 1/7/13, listed trazodone as the drug requiring consent and the target behaviors being monitored for the trazodone use were listed as restless, sleep disturbance, constant worrying, and difficulty initiating or maintaining sleep. No monitoring of the "restless" or "constant worrying" target behaviors could be located in the record. Monitoring for side effects of the trazodone was documented on the Inter Disciplinary Flow Sheet for the day and evening shifts, but not the night shift. No documentation of effectiveness of non-pharmacological interventions for sleep was found in the record. When interviewed on 3/4/13 at 3:30 p.m., the assistant director of nursing confirmed there was no monitoring of the identified target behaviors of "restless" and "constant worrying." She acknowledged that the effectiveness of non-pharmacological sleep interventions were not documented. She also acknowledged that side effects monitoring was not included on the night shift flowsheets, and stated that those forms had been changed recently and the side effects monitoring portion may have been accidentally left out of the night shift Inter Disciplinary Flow Sheet. The Record of Medication Regimen Review in the record showed that a drug regimen review had been completed by a consulting pharmacist on 12/20/12, 1/3/13, and 2/1/13. This form contained no documentation of irregularities with	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 428	Continued From page 8 reference to monitoring of target behaviors, monitoring of side effects of trazodone, or effectiveness of non-pharmacological interventions for sleep disturbance. When interviewed on 2/28/13 at 11:40 a.m., the director of nursing stated that more details regarding sleep were added to the Target Behavior section of the Inter Disciplinary Flow Sheet form within the last 1-2 months. She explained that these were added after a conversation in which the consulting pharmacist advised the facility that they needed to collect more information regarding a resident's sleep when the resident is using a sleep medication. Sections were added to the Inter Disciplinary Flow Sheet to address hours of sleep on a shift, sleep patterns, and interventions attempted. During interview on 2/28/13 at 12 p.m., the consulting pharmacist stated that he attended quality assurance meetings at the facility and in those meetings he had discussed the need for more documentation of information regarding the sleep of residents using sleep medication, and since those discussions some of the forms used by the facility have been changed. When asked if he felt all the changed needed had been completed, he replied that it was an ongoing process. On 3/1/13 the facility's consulting pharmacist provided a written statement to the facility stating that he had discussed his recommendations to the facility regarding sleep monitoring with a surveyor on 2/28/13 and wrote, "I shared with (surveyor's name) that I had identified a potential problem regarding the documentation associated	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 428	Continued From page 9 with the used of PRN trazodone, and had communicated my concerns to the Director of Nursing via regular consulting notes for several residents. I also shared with (surveyor's name) that, in my role as part of the Quality Assessment and Assurance team, I had worked with the Director of Nursing to develop and implement a system to address the system concerns I had identified. The Director of Nursing and her staff have implemented this system, and I continue to monitor and evaluate the overall use of PRN medications of all types used by residents in the facility."	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	Capitol View Transitional Care Center does have an established infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A. Patient R217 has discharged. B. RN - A has been re-educated on the importance of proper hand hygiene. All licensed staff will be retrained on the importance of proper hand hygiene, especially during a dressing change. C. Nursing Management or designee has been directed to watch for proper hand hygiene, especially during dressing changes. An audit tool will be implemented to assure compliance. D. The Interdisciplinary team members remain responsible	4/1/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 441	Continued From page 10 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene was maintained prior to and after direct resident contact for 1 of 2 residents (R217) in the sample whose dressing change was observed. Findings include: On 2/27/13, at 10:09 a.m. R217's dressing change was observed. The registered nurse (RN) -A used an alcohol based foam hand sanitizer prior to donning gloves. With gloved hands RN-A removed R217's soiled dressing. RN-A then removed his soiled gloves and left the room to obtain additional supplies. RN-A did not wash his hands or use a alcohol based foam hand sanitizer to clean his hands prior to leaving the resident's room. When RN-A returned he cleaned his hands with the alcohol based foam hand sanitizer, applied a pair of gloves and proceeded to apply a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 441	Continued From page 11 Betadine (an antiseptic) swab to the surgical incision on the resident's foot. RN-A then poured one ounce of Hibicleanse into a 500 mls (milliliters) bottle of normal saline (NS). RN-A then poured some of the solution into the cap of the bottle, placed a gauze pad in the cap to saturate it with the solution and proceeded to clean the pressure ulcer on R217's right heel with the gauze pad. With his gloved hands RN-A then picked up a second bottle containing 500 mls of NS, poured some of the NS into the cap of the bottle, placed a gauze pad in the cap to saturate it with the solution and proceeded to rinse the pressure ulcer on R217's right heel with the gauze pad. With his gloved hands, RN-A then reached into a wash basin containing dressing supplies to obtain a gauze dressing to pat dry the wound. With his gloved hands RN-A then reached into the same wash basin to obtain a paper ruler to measure the wound. With gloved hands RN-A reached into the basin again to obtain a non-adherent pad and applied this to the resident's pressure ulcer. With gloved hands RN-A reached into the basin again to obtain a roll of gauze and proceeded to wrap the R217's foot. With gloved hands RN-A reached into the basin again to obtain a elastic bandage and proceeded to wrap R217's foot with the bandage. RN-A then removed his soiled gloves and proceeded to apply a soft, Velcro shoe, adjust the position of R217's lower extremities on a pillow and placed the wound care supplies in the basin and returned the basin to R217's closet prior to washing his hands. On 2/27/13, at 10:40 a.m. RN-A stated the dressing change was not a sterile procedure and he believed he maintained a clean technique.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 441	Continued From page 12 When informed that after removing the soiled dressing and gloves he left the room without washing hands or using hand sanitizer RN-A confirmed this and stated, he used a foam sanitizer after he left the room and "I guess you would not have known that." When RN-A was informed that he handled the NS bottles and reached into the basin multiple times to obtain dressing supplies with his soiled gloves and then returned the supplies to the cabinet in the resident's room for later use. RN-A stated, he will dispose of the contaminated supplies as soon as we are finished talking. On 2/28/13, at 3:30 p.m. the director of nursing (DON) and the facilities infection control nurse stated staff are expected to wash their hands with soap and water after removing gloves when performing wound care. The facility's Wound Care policy "revised November 2013" directed staff to establish a clean field. Place all items to be used during the procedure on the clean field, wash and dry their hands thoroughly prior to beginning the wound care, after removing the soiled dressing, and again when finished with the dressing change and before repositioning the resident.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING **02 - CAPITAL VIEW TRANSITIONAL CARE UNIT** B. WING _____	**02/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	**640 JACKSON STREET** **SAINT PAUL, MN 55101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, at the request of Minnesota Department of Health. At the time of this survey, Capitol View Transitional Care Center, located on the 8th floor of Regions Hospital, was found to be 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. This 10-story building was constructed in 1965, and was determined to be of Type I(332) construction. The building has a full basement and is fully fire sprinklered. The building has a fire alarm system, with smoke detection in spaces open to the corridor and in all resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 31 beds at the time of this survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 000		

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

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