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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N1DZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00480

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/22/2014** (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)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

On 8/22/14, a second Post Certification Revisit (PCR) was completed by the Department of Health, bringing the facility into compliance. Mandatory DPNA was rescinded.

17. SURVEYOR SIGNATURE Date :
Thomas Linhoff, SFMO 08/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/25/2015 (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
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/19/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5340

March 26, 2015

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

Dear Mr. Thompson:

It has come to our attention that we failed to send you the following notice after the post certification revisit of August 22, 2014:

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 August 4, 2014 the above facility is certified for:

112 - Skilled Nursing Facility/Nursing Facility Beds

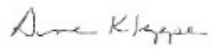
Your facility's Medicare approved area consists of all 112 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,



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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4653

August 28, 2014

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

RE: Project Number S5340023

Dear Mr. Thompson:

On August 19, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 12, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of August 19, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 12, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on June 12, 2014, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our August 19, 2014 notice. The most serious LSC deficiencies in your facility at the time of the standard survey 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.

On July 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 4, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 12, 2014, as of August 4, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of August 19, 2014. The CMS Region V Office concurs and has authorized this Department to

notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 12, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 12, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 12, 2014, is to be rescinded.

In our letter of August 19, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 12, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 4, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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 A. Building B. Wing	(Y3) Date of Revisit
245340	01 - MAIN BUILDING	8/22/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	08/04/2014	ID Prefix Reg. # NFPA 101 LSC K0029	08/04/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
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	08/28/2014	12424	08/22/2014
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
6/11/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N1DZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00480

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/28/2014** (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)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
The life safety code portion of the survey has not yet been verified, therefore, Mandatory Denial of Payment for New Admissions (DoPNA), is effective 09/12/14.

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 07/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS
Posted 08/25/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4592

August 19, 2014

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

RE: Project Number S5340023

Dear Mr. Thompson:

On July 1, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 12, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 28, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 4, 2014. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on June 12, 2014.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the June 12, 2014 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 12, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 12, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 12, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Galtier Health Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 12, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the July 28, 2014 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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 December 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 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
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245340	A. Building B. Wing	7/28/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **07/22/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/22/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **07/22/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	07/28/2014	16022	07/29/2014
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
6/12/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N1DZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00480

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245340**

2.STATE VENDOR OR MEDICAID NO.
(L2) **650343800**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/12/2014** (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)
09/30

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

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

13.Total Certified Beds 112 (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Vidya Tomar - NEII 07/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS
Posted 08/19/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5170

June 30, 2014

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

RE: Project Number S5340023

Dear Mr. Thompson:

On June 12, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

<u>Informal Dispute Resolution</u> - 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, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
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 July 22, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422), effective September 12, 2014

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 September 12, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALTIER HEALTH CENTER	445 GALTIER AVENUE SAINT PAUL, MN 55103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED JUL - 9 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272	1. RESIDENT #139 HAS BEEN COMPREHENSIVELY ASSESED. 2. A THOROUGH COMPREHENSIVE ASSESSMENT WILL BE COMPLETED ON ALL RESIDENTS UPON ADMISSION AND INITAITION OF PSYCHOTROPIC MEDICATIONS. 3. SOCIAL SERVICES AND NURSING HAVE BEEN RE-EDUCATED ON PERFORMING A COMPREHENSIVE ASSESSMENT ON ALL RESIDENTS. 4. SOCIAL SERVICES / DESIGNER WILL AUDIT 4 CARE PLANS PER WEEK TO ENSURE THAT THEY ARE COMPREHENSIVE. RESULTS OF AUDITS WILL BE REVIEWED IN QPI.	08/04/14

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

7-8-14

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

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F 272	Continued From page 1 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to do a thorough comprehensive assessment upon admission before starting 1 of 5 residents (R139) on psychotherapeutic medications. Findings include: R139 was admitted from the hospital 1/11/14 and on 1/12/14 was placed on Seroquel with out having a thorough assessment of behaviors. R139 was admitted to the nursing home on 1/11/14 following a fall at home resulting in a fractured hip which was repaired, and a shoulder fracture for which she required a sling. R139 had been living alone prior to hospitalization. Other diagnoses included hypertension, tobacco use, breast cancer and depression.	F 272		

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

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F 272	Continued From page 2 Nurses notes (NN) on 1/12/14 at 11:00 a.m. revealed increased agitation (not specified). A physician order was received to start Seroquel (an antipsychotic) 25 mg at bed time (HS) and every 8 hours (q8hrs) as needed (PRN). (The physician orders dated 6/9/14 indicated the Seroquel is being given for depression.) NN at 11:15 a.m., indicated resident wanted to sign out against medical advise (AMA). The resident said if I have to be here I will kill myself. About ten minutes after the statement, R139 said she would stay. At 7:00 p.m. resident again stated she wanted to get out of this hell hole and torture chamber. The resident agreed to stay the night. On 1/13/14 a urine culture was ordered and on 1/17/14 the urine culture came back positive for a urinary tract infection. R139 was started on an antibiotic. The nurse practitioner (NP) notes on 1/13/14 indicated resident had exhibited agitation since admission, delirium, confusion and stated she wanted to go back to the hospital. The NP indicated the resident was unable to carry on an appropriate conversation. The Seroquel given on the weekend was not effective in decreasing the agitation, so the NP increased the Seroquel to 50 mg twice a day (BID). The other medications the resident was currently receiving included Cymbalta 60 mg every day (QD) for depression, started on 1/11/14 and Trazodone 50 mg HS for alcohol abuse/depression, started on 1/15/14. The resident remained on these medications at the current dosages. The admission minimum data set (MDS) dated 1/21/14 indicated mild depression with no behaviors. The brief interview for mental status (BIMS) which indicated cognition revealed R139	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 3 was only slightly confused with a score of 13/15. The care area assessment (CAA) dated 1/21/14 did not identify any behavioral issues. When interviewed on 6/11/14 at 2:45 p.m., licensed practical nurse (LPN)-A indicated upon admission the resident was very agitated and she confirmed the resident was started on medication before a thorough assessment could be completed. LPN-A and registered nurse (RN)-A confirmed the resident had just gone through major surgery and had a UTI which could be contributing to the behaviors.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise plan of care for 1 of 1 resident (R1) in the sample who needed passive range of motion (PROM) daily. Findings include: Resident (R1)'s plan of care was not revised to direct staff as to which extremities needed how many repetitions of PROM to prevent further decrease in range of motion (ROM) to right upper and lower extremities. During observations of R1 on 06/11/14 at 7:35 a.m. nursing assistant (NAR)-A wheeled R1 into the dining room, R1's right fingers clenched her hand splint. On 06/12/14 at 8:45 a.m. observed R1 laying in her bed with her right hand brace on. R1 was admitted to the facility on 03/19/1999, Occupational Therapy (OT) plan of care, dated 01/03/13 indicated R1 had diagnoses that included left cerebrovascular accident (CVA) stroke with right sided hemiplegia (right sided weakness) and required hand splint and therapy to improve right hand function. The nursing program plan, "Restorative Resident Summary Report," dated 05/12/14 to 06/10/14 indicated staff to provide PROM to right lower and upper extremities twice daily to prevent a decline in ROM. The daily tasks were listed as such: did R1 participate in PROM program, how many minutes of PROM was provided, and how well did R1 tolerate? The plan of care/program's documentation revealed the staff had conducted PROM once a day for a range of 2 to 15 minutes	F 280	1. RESIDENT #1 HAS HAD HER RESTORATIVE PLAN OF CARE REVIEWED AND REVISED. 2. ALL RESIDENTS THAT HAVE PROM CARE PLANS HAVE BEEN REVIEWED AND REVISED. 3. RESTORATIVE NURSE AND LICENSED STAFF HAVE BEEN EDUCATED ON PROM PLAN OF CARE. 4. DIRECTOR OF NURSING/DESIGNEE WILL AUDIT 4 PROM PLANS OF CARE PER WEEK TO ENSURE PROGRAMS APPROPRIATENESS. RESULTS OF AUDITS WILL BE REVIEWED AT QPI.	08/04/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 5 each time. The plan of care/program lacked specific instruction for staff as to how many repetitions of PROM the staff needed to complete on each of the extremities. It did not specify which joints were needing PROM for upper extremities and which joints for lower extremities needed PROM to sustain/improve functioning. On 06/12/14 at 8:45 a.m. NAR-A indicated she performed PROM to R1's upper and lower extremities this morning before getting R1 up for breakfast. When asked how she did it and number of repetitions done, NAR-A responded, "Oh well, sometimes 5, sometimes 10 (repetitions), it just depends." She stated, she documented in the Care Tracker, computerized documentation of how many minutes it took her to perform PROM. On 06/12/14 at 11:00 a.m. registered nurse (RN)-A indicated after reviewing the PROM plan of care/program that both upper and lower extremity data was combined, which needed to be separated to evaluate the program goal, which was not to decline in ROM. RN-A stated the restorative RN (RN)-B revised the plan of care/program based on therapies recommendations. On 06/12/14 at 11:30 a.m. RN-A was present and RN-B indicated she developed and revised the PROM plans/programs based on therapies recommendations. RN-B indicated after reviewing the plan/program for R1's PROM, that it needed to be specific and individualized; including number of repetitions, specific joints needing PROM to evaluate the plan goal. RN-B	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 6 stated she documented a monthly note on R1's PROM; reviewed 04/24/14 and 06/03/14 notes, which stated R1 has maintained ROM to right upper/lower extremities with assist of on staff to perform PROM twice daily and would continue plan of care. On 06/12/14 at 2:35 p.m. RN-B provided revised program documentation for R1, dated 06/12/14 indicating, "staff to provide PROM to (R) upper extremity twice daily, (R) elbow 25 reps, hand and fingers 5-10 reps, knuckle 5-10 reps. In addition the documentation revealed a goal to prevent further contracture of right upper extremities by performing PROM twice daily with certain degrees of extensions. The degrees were documented to assist staff with PROM. The restorative nursing program policy/procedures, revised January 2012, directed staff to review applicable program for techniques and interventions to enable residents to attain or maintain their highest practicable level of physical, mental, and psychosocial functioning. Increased independence fosters self-esteem and promotes positive quality of life for residents.	F 280		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	1. RESIDENT #1 HAS RECEIVED PROM SERVICES TO PREVENT FURTHER DECREASE 2. ALL OTHER RESIDENTS WITH PROM HAVE RECEIVED, PROM AND CARE PLANS HAVE BEEN REVEIWED AND REVISED. 3. RESTORATIVE NURSE AND LICENSED STAFF HAVE BEEN EDUCATED ON PROVIDING PROM PER PLAN OF CARE.	08/04/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 318	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide passive range of motion (PROM) services to prevent further decrease in PROM for 1 of 1 resident (R1) whose plan of care was not revised. Findings include: During observations of R1 on 06/11/14 at 7:35 a.m. nursing assistant (NAR)-A wheeled R1 in the dining room, R1's right fingers clenched her hand splint. On 06/12/14 at 8:45 a.m. observed R1 laying in her bed with her right hand brace on. R1 was admitted to the facility on 03/19/1999, Occupational Therapy (OT) plan of care, dated 01/03/13 indicated R1 had diagnoses that included left cerebrovascular accident (CVA) stroke with right sided hemiplegia (right sided weakness); right hand contracture and required hand splint and therapy to improve right hand function. The nursing program plan, "Restorative Resident Summary Report," dated 05/12/14 to 06/10/14 indicated staff to provide PROM to right lower and upper extremities twice daily to prevent a decline in ROM. The daily tasks were listed as such: did R1 participate in PROM program, how many minutes of PROM was provided, and how well did R1 tolerate? The plan of care/program's documentation revealed the staff had conducted PROM once a day for a range of 2 to 15 minutes each time. The plan of care/program lacked specific	F 318	4. RESTORATIVE NURSE/DESIGNEE WILL AUDIT 4 RESTORATIVE PROGRAMS PER WEEK TO ENSURE PROGRAMS APPROPRIATENESS. RESULTS OF AUDITS WILL BE REVIEWED AT QPI.	08/04/14

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F 318	Continued From page 8 instruction for staff as to how many repetitions of PROM the staff needed to complete on each extremities. It did not specify which joints were needing PROM for upper extremities and which joints for lower extremities needed PROM to sustain/improve functioning. Resident (R1)'s plan of care was not revised to direct staff as to which extremities needed how many repetitions of PROM to prevent further decrease in range of motion (ROM) to right upper and lower extremities. On 06/12/14 at 8:45 a.m. NAR-A indicated she performed PROM to R1's upper and lower extremities this morning before getting R1 up for breakfast. When asked how she did it and number of repetitions done, NAR-A responded, "Oh well, sometimes 5, sometimes 10 (repetitions), it just depends." She stated, she documented in the Care Tracker, computerized documentation of how many minutes it took her to perform PROM. On 06/12/14 at 11:00 a.m. registered nurse (RN)-A indicated after reviewing the PROM plan of care/program that both upper and lower extremity data was combined, which needed to be separated to evaluate the program goal, which was not to decline in ROM. RN-A stated the restorative RN (RN)-B revised the plan of care/program based on therapies recommendations. On 06/12/14 at 11:30 a.m. RN-A was present and RN-B indicated she developed and revised the PROM plans/programs based on therapies recommendations. RN-B indicated after reviewing the plan/program for R1's PROM, that it	F 318		

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F 318	Continued From page 9 needed to be specific and individualized; including number of repetitions, specific joints needing PROM to evaluate the plan goal. RN-B stated she documented a monthly note on R1's PROM; reviewed 04/24/14 and 06/03/14 notes, which stated R1 has maintained ROM to right upper/lower extremities with assist of on staff to perform PROM twice daily and would continue plan of care. On 06/12/14 at 2:35 p.m. RN-B provided revised program documentation for R1, dated 06/12/14 indicating, "staff to provide PROM to (R) upper extremity twice daily, (R) elbow 25 reps, hand and fingers 5-10 reps, knuckle 5-10 reps. In addition the documentation revealed a goal to prevent further contracture of right upper extremities by performing PROM twice daily with certain degrees of extensions. The degrees were documented to assist staff with PROM. The restorative nursing program policy/procedures, revised January 2012, directed staff to review applicable program for techniques and interventions to enable residents to attain or maintain their highest practicable level of physical, mental, and psychosocial functioning. Increased independence fosters self-esteem and promotes positive quality of life for residents.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	1. RESIDENT #139 HAS BEEN ASSESED AND NON-PHARMACOLOGICAL INTERVENTIONS HAVE BEEN PUT IN PLACE FOR TARGET BEHAVIORS AND APPROPRIATE DIAGNOSIS REVIEWED. 2. ALL RESIDENTS RECEIVING PSYCHOACTIVE MEDICATIONS HAVE BEEN ASSESED AND DIAGNOSIS WITH BEHAVIORS IDENTIFIED WITH	7/23/14 08/04/14

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F 329	Continued From page 10 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 interview and document review, the facility failed to assess, provide justification for the start and continued use of a psychoactive medication, failed to implement and monitor non pharmacological interventions for 1 of 5 residents (R139) reviewed for unnecessary medication use. Findings include: The facility did not implement non-pharmological interventions upon admission to the facility before adding Seroquel (an antipsychotic) to R139's medications. R139 was admitted to the nursing home on 1/11/14 following a fall at home resulting in a	F 329	NON-PHARMACOLOGICAL INTERVENTIONS IN PLACE. 3. SOCIAL SERVICES AND NURSING HAVE BEEN RE-EDUCATED ON ASSESSMENTS THAT IDENTIFY TARGET BEHAVIORS AND IMPLEMENTING NON-PHARMACOLOGICAL INTERVENTIONS AND APPROPRIATE DIAGNOSIS. 4. DIRECTOR OF SOCIAL SERVICES/ DESIGNEE WILL AUDIT 4 CARE PLANS PER WEEK TO ENSURE APPROPRIATE ASSESSMENTS AND INTERVENTIONS. RESULTS OF AUDITS WILL BE REVIEWED IN QPI.	08/04/14

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F 329	Continued From page 11 fractured hip and shoulder fracture. R139 had been living alone prior to hospitalization. R139 also had diagnoses that included hypertension, tobacco use, breast cancer, and depression. On the second day of admission to the facility, nurses notes (NN), dated 1/12/14 at 11:00 a.m., identified R139 had increased agitation. NN at 11:15 a.m., indicated resident wanted to sign out against medical advise (AMA). Resident said, "if I have to be here I will kill myself." About ten minutes later resident said she would stay. At 7:00 p.m. resident again stated she wanted to get out of this hell hole and torture chamber. The resident agreed to stay the night. There was no documentation which indicated non pharmacological interventions had been implemented. A physician order was received to start Seroquel (an antipsychotic) 25 mg at bed time (HS) and every 8 hours (q8hrs) as needed (PRN). On 1/13/14 a urine culture was ordered, due to increase in agitation, and on 1/17/14 results identified R139's urine culture was positive for a urinary tract infection. The nurse practitioner (NP) notes on 1/13/14 indicated resident had exhibited agitation since admission, delirium, confusion and stated she wanted to go back to the hospital. The NP indicated the resident was unable to carry on an appropriate conversation. The Seroquel given on the weekend was not effective in decreasing the agitation, so the NP increased the Seroquel to 50 mg twice a day (BID). R139 was also receiving Cymbalta 60 mg every day (QD) for depression, started on 1/11/14 and Trazodone 50 mg HS for alcohol abuse/depression, started on 1/15/14.	F 329		

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F 329	Continued From page 12 The admission minimum data set (MDS) dated 1/21/14 indicated mild depression with no behaviors. The brief interview for mental status (BIMS) which indicated cognition revealed R139 was only slightly confused with a score of 13/15. A significant change MDS was completed on 3/28/14 and R139 scored 15/15 on the BIMS and was mildly depressed. The MDS revealed some verbal behaviors were present, occurring 1-3 days, although the behaviors were not significant and did not impact others. R139's current mood care plan (CP) dated 1/21/14 indicated mild depression, wanting to go home and several non pharmacological interventions directed the staff to do 1 to 1's offer support, listen, and identify staff who work well with her. The CP identified an adjustment problem accusing staff of killing her by keeping her in this place. Interventions were, 1 to 1's, offer support, listen, and identify staff who work well with her. The behavior CP indicated will swear at staff, demented with delirium and delusions. NP notes on 1/29/14 indicated resident was not depressed, anxious or agitated. On 2/13/14 the NP notes indicated R139 was on Cymbalta and Seroquel for depression and mood state. The NP did not address any behaviors. On 2/21/14 the physician decreased the Seroquel to 25 mg bid due to the decrease in delirium. The nurses notes on 2/23/14 at 9:00 p.m. indicated R139 complained that another resident made sexual comments down in the smoking lounge. The resident and the other accused male	F 329		

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F 329	Continued From page 13 resident were put on supervised smoking privileges. On 2/24/14 at 11:00 a.m., the nurses notes described the residents behavior as extremely agitated, yelling and wanting to go down to the smoking room. Resident was reminded of the the incident yesterday with another male resident, however R139 did not remember the incident. Resident was wearing an "alert" braclet which did not allow the elevator door to shut. This made R139 more agitated. NP was called on 2/24/14 and increased the Seroquel back up to 50 mg bid. On 2/25/14 the behavior of making false accusations against staff and other residents was added to the CP. Some of the interventions directed the staff to provide 1 to 1's, offer support, listen, identify staff who work well with her, redirect, and remove from situation. The NP notes on 3/3/14 described resident as oriented to self only with delusions not delirium, and dementia with behavioral disturbances. No medication changes made. On 4/7/14 the NP noted no behaviors. Indicated resident with dementia and history of delusions. No nursing concerns and resident independent with activities of daily living (ADL's). Noted that the resident was on Seroquel and trazodone for sleep. Resident not depressed, agitated, anxious or any overt confusion. Medications not changed. Physician note on 4/29/14 indicated dementia, has delusions (not specified), and depression stable, Continue Cymbalta 60 mg, Seroquel 50 mg bid and Trazodone 50 mg HS. The Target Behavior Program Summary Reports from January to the present were reviewed. The form identified the behaviors as, increased	F 329		

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F 329	Continued From page 14 agitation, delusions, and stating she wanted to die if she had to stay and staff were killing her by making her stay. Non pharmacological interventions were listed however there was no indication the interventions were implemented during the few times the resident exhibited any of the behaviors. Consult with gero psychology on 2/5/14 for dementia and delusional thinking. Diagnostic impressions were likely diagnosis of major depressive episode, recurrent, moderate, and major neuro cognitive disorder due to multiple etiologies with behavioral disturbances. Non pharmacological interventions were suggested which included socialization with other residents, promote reading which she enjoys, bring to music events which would improve her mood, reminisce about her work as a travel agent and travel. The suggested non pharmacological interventions were not implemented. When interviewed on 6/11/14 at 2:30 p.m., registered nurse (RN)-A indicated all behavior documentation is in care tracker on the Target Behavior Summary Report forms and indicated interventions should be in there also. The CP has the nonpharmacological interventions identified and the Target Behavior Summary Report form is where they are documented. 6/12/14 at 1:30 p.m., DON indicated care tracker on the Target Behavior Summary Report forms is where the interventions should be documented as to what we do and confirmed the Target Behavior Summary Report forms did not identify the non pharmacological interventions. On 6/12/14 at 3:40 p.m. the nurse practitioner	F 329		

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F 329	Continued From page 15 (NP)-D was interviewed and indicated she definitely would expect non pharmacological interventions to be used first to try to alleviate behaviors. NP-D stated not having talked to pharmacy about the medications and added that the Seroquel was started for aggressive and disruptive behavior. NP-D did not know if non pharmacological interventions were tried first, before the Seroquel was started. The policy and procedure revised 10/12, titled, Target Behavior/Target Mood Occurrences indicated staff to note ineffective interventions for a target behavior on care tracker using the mood and behavior section. Review the target behaviors as needed and update if needed to reflect current behaviors and/or interventions for appropriateness, along with the appropriateness of current antipsychotics. The policy and procedure revised 8/08, titled, Psychoactive Medications indicated psychoactive medications are used with but not limited to failure of non drug choices, to maintain or improve function, benefits outweigh the risks, and for treatment of documented, medically supported psychiatric diagnosis and identified target behaviors.	F 329	[illegible]	
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 categpries of licensed and unlicensed nursing staff directly responsible for	F 356	1. FACILITY REVIEWED AND REVISED POSTED STAFFING INFORMATION TO INCLUDE ACTUAL NURSE STAFFING HOURS AND CENSUS IN A CLEAR AND UNDERSTANDABLE MANNER. 2. STAFFING COORDINATOR AND LICENSED STAFF WILL USE THIS FORMAT EVERYDAY TO ENSURE COMPLIANCE.	7/25/14 08/04/14

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F 356	Continued From page 16 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post actual nurse staffing hours data in a clear and understandable manner. This had the potential to impact all 99 residents, staff and visitors who may want to view nurse staffing data. Findings include: On 6/9/14 at noon, the Daily Nurse Staffing Form was observed in the entry way to the facility. The number of hours worked by the night and day staff were not calculated for each category of	F 356	3. STAFFING COORDINATOR AND LICENSED HAVE BEEN EDUCATED ON REQUIREMENTS OF POSTED NURSE STAFFING INFORMATION. 4. ADMINISTRATOR/DESIGNEE TO PERFORM DAILY AUDITS TO ENSURE ALL REQUIRED COMPONENTS ARE INTACT ON POSTED FORM. RESULTS OF AUDITS WILL BE REVIEWED AT QPI.	7/22/14 08/04/14

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F 356	Continued From page 17 nursing staff, nursing assistant (NA), licensed practical nurse (LPN) and registered nurse (RN). Under staffing total for each category was a number of "FTE"s. No definition or explanation for "FTE" was provided on the form. Daily Nurse Staffing Form for 6/7/14 to 6/12/14 were reviewed. At least one shift for each form did not have the number of hours worked by each category of nursing staff. On 6/12/14 at 3:00 p.m. the staffing coordinator reported she was not aware the number of hours worked by each category of nursing staff needed to be on the form.	F 356		
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 interview and document review the consulting pharmacist did not inform the facility staff about providing non-pharmacological interventions and also justification for use of psychotropic medications for 1 of 5 residents R139 reviewed for unnecessary drugs.	F 428	1. RESIDENT #139 MEDICATIONS AND DIAGNOSIS HAVE BEEN REVIEWED BY PHARMACIST + INTERVENTIONS HAVE BEEN PUT INTO PLACE. 2. PHARMACIST TO REVIEW ALL RESIDENTS MEDICATIONS MONTHLY AND REPORT ANY IRREGULARITIES TO ATTENDING PHYSICIAN AND DON AND THESE REPORTS WILL BE ACTED ON 3. EDUCATED PHARMACY CONSULTANT ON REVIEWING AND MAKING RECOMMENDATIONS FOR POTENTIAL UNNECESSARY MEDICATIONS. 4. DON AND DIRECTOR OF SOCIAL SERVICES TO AUDIT 4 CHART PER WEEK TO ENSURE MEDICATIONS HAVE APPROPRIATE DIAGNOSIS, NON - PHARMACOLOGICAL INTERVENTION, AND ARE NECESSARY MEDICATIONS. RESULTS OF AUDITS WILL BE REVIEWED AT QPI.	7/25/14 08/04/14

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F 428	Continued From page 18 Findings include: The pharmacist did not advise the facility about justification for the use of psychotherapeutic medications and for the use of non pharmacological interventions. R139 was admitted to the nursing home on 1/11/14 following a fall at home resulting in a fractured hip which was repaired, and a shoulder fracture for which she required a sling. R139 had been living alone prior to hospitalization. Other diagnoses included hypertension, tobacco use, breast cancer and depression. Nurses notes (NN) on 1/12/14 at 11:00 a.m. revealed increased agitation (not specified). A physician order was received to start Seroquel (an antipsychotic) 25 mg at bed time (HS) and every 8 hours (q8hrs) as needed (PRN). The physician orders dated 6/9/14 indicated the Seroquel was being given for depression. On 1/13/14 the nurse practitioner (NP) increased the dosage to 50 mg bid. The other medications the resident was currently receiving included Cymbalta 60 mg every day (QD) for depression, started on 1/11/14 and Trazodone 50 mg HS for alcohol abuse/depression, started on 1/15/14. The consultant pharmacist noted on 1/17/14 Cymbalta 60 mg and 1/13 increase Seroquel 50 mg bid dementia with delusions. On 2/17/14 the pharmacist noted, 1/24 Trazodone 50 mg HS. On 3/18/14 the pharmacist noted the decrease and increase of the Seroquel with no other recommendations. On 6/12/14 at 3:40 p.m. the nurse practitioner (NP)-D was interviewed and indicated she had	F 428		

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F 428	Continued From page 19 not talked to pharmacy about the medications. The pharmacist was interviewed on 6/17/14 at 4:25 p.m. She could not recall making any recommendations to the staff other than to do side effect monitoring for the antipsychotic. The policy and procedure revised 8/08, titled, Psychoactive Medications indicated review of psychoactive medications may include the pharmacy recommendations.	F 428		
F 431 SS=E	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	F 431	1. ALL EXPIRED MEDICATIONS FOR RESIDENTS #164, #75, #161, #28, #97, #53, #51, AND #103 WERE PROPERLY DISPOSED. 2. EXPIRED MEDICATIONS ARE TO BE PROPERLY DISPOSED OF IMMEDIATELY THROUGH OUT CENTER. 3. ALL NURSING STAFF EDUCATED ON IMPORTANCE OF REMOVING EXPIRED MEDICATION IMMEDIATELY FROM ALL STORAGE AREAS USING PROPER DISPOSAL. 4. NURSE MANAGERS/DESIGNEE TO PERFORM WEEKLY AUDITS OF THE MEDICATION CARTS AND MEDICATION ROOMS AND REPORT TO DON. RESULTS OF AUDITS WILL BE REVIEWED AT QPI.	7/22/14 08/04/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALTIER HEALTH CENTER	445 GALTIER AVENUE SAINT PAUL, MN 55103

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F 431	Continued From page 20 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: Based on observation, interview and document review, the facility failed to discard expired medications from medication storage areas impacting 8 of 31 residents (R164, R75, R161, R28, R97, R53, R51, R103) whose medications were observed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R164, R75, R161, R28, R97, R53, R51 and R103, which included insulin, inhaler, eye drops and oral medications, lacked dates to indicate when they were opened or when the medications expired. During the medication storage tour on 6/9/14 at 6:07 p.m., with registered nurse (RN)-C, on third floor, multiple opened and expired medications were stored in the medication cart. Observations included the following: R164's Lantus insulin vial was expired with an opened date of 4/24/14. R75's Advair HFA inhaler was expired with an opened date of 3/30/14. During interview on 6/9/14 at 6:07 p.m., RN-C	F 431		

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F 431	Continued From page 21 verified the medications needed to be stored properly, with proper date when opened. Further, RN-C stated, she will remove expired medications from the medication cart. During the medication storage tour on 6/9/14 at 6:27 p.m. the fourth floor medication storage cart two was reviewed with RN-D. The following observations were made: R161's dorzolamide-timolol (glaucoma) eye drop bottle was opened, used and dated of 4/17/14. R28's artificial tears eye drop bottle was opened, used and dated on 4/20/14. During interview on 6/9/14 at 6:27 p.m., RN-D verified the medications needed to be labeled and stored properly. During the medication storage tour on 6/9/14 at 6:30 p.m., the fourth floor medication storage cart one was reviewed with RN-E and RN-F. The following observations were made: R97's Timolol maleate (glaucoma) eye drop bottle was opened, used and undated. R53's artificial tears eye drop bottle was opened, used and dated 3/29/14. Fourth floor medication room was reviewed. The following observations were made: Two stock bottles of multi vitamin with iron (one-daily) with the expiration date of 5/14 was noted. During interview on 6/9/14 at 6:30 p.m., RN-E and RN-F verified the medications needed to be labeled and stored properly. During the medication storage tour on 6/9/14 at 6:45 p.m., the first floor medication storage cart	F 431		

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F 431	Continued From page 22 was reviewed with licensed practical nurse (LPN)-B. The following observations were made: R51's dorzolamide-timolol (glaucoma) eye drop bottle was expired with an opened date of 5/17/14. During interview on 6/9/14 at 6:45 p.m. LPN-B verified the medications needed to be labeled and stored properly. During the medication storage tour on 6/9/14 at 7:05 p.m., second floor medication storage cart one was reviewed with LPN-C. The following observations were made: R103's Proair HFA inhaler was opened and dated 3/10/14. During interview on 6/9/14 at 7:05 p.m. LPN-C verified the medications needed to be labeled and stored properly. During interview on 6/11/14 at 9:13 a.m., the director of nursing (DON) indicated, her expectation was for staff to date all multiple dose medication bottles when they opened them. Policy and procedure titled: Storage of drugs dated 9/06, read, "A. All drugs in the nursing stations shall be stored under the following conditions: 6. Drugs shall not be kept on hand after the expiration date on the label and no contaminated or deteriorated drugs shall be available." The insulin storage recommendations, dated 9/30/13, indicated, to discard Insulin 28 days after opened. In addition, the recommended minimum medication storage parameters, dated 9/30/13, reads, "Date the Diskus when removed from the	F 431		

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F 431	Continued From page 23 foil pouch and discard 1 month after removal from foil pouch or after all blisters have been used, whichever comes first."	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a door which shut properly, impacting 2 of 4 residents (R127 and R31). Findings include: On 6/10/14 at 8:50 a.m. surveyor attempted to shut the door of the room occupied by R127 and R31. The door would not shut and latch, despite a firm tug. The door was noted to be splintering at the top. On 6/11/14 at 10:15 a.m., during tour with the maintenance director, the door was again not able to be shut, despite a firm tug. The door was splintering on top and made a creaking sound. The maintenance director confirmed findings and noted the door would need to be fixed. At 2:00 p.m., a Building Services Work Order Request form, dated 6/11/14, was reviewed. The form read "building work order-any staff can complete request to have things fixed. Fire drills	F 465	1.DOOR HAS BEEN REPAIRED AND IS NOW LATCHING PROPERLY. 2. ALL DOORS AT CENTER HAVE BEEN CHECKED AND ARE ALL FUNCTIONING CORRECTLY. 3. MAINTENANCE DIRECTOR HAS BEEN EDUCATED ON PROPER DOOR CLOSURE AND LATCHING. 4. MAINTENANCE DIRECTOR TO AUDIT 30 DOORS PER WEEK FOR PROPER FUNCTIONING. RESULTS OF AUDITS WILL BE REVIEWED AT QPI.	7/22/14 08/04/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 24 3x month. All doors need to be shut. This door will be fixed."	F 465		

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	245340	A. BUILDING 01 - MAIN BUILDING B. WING _____	06/11/2014

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY At the time of this survey, Galtier Health Center was found not to be in substantial compliance with the requirements for participation in Medicare/ Medicaid, 42 CFR, Subpart 483.70 (a), Life Safety from Fire, and National Fire Protection Association (NFPA) Standard 101-2000 edition. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE	K 000	POC ok 8-11-14 RECEIVED AUG 11 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 6-12-14 DC: 7-22-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		8-8-14

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

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K 000	Continued From page 1 FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency This 4-story building was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered. The facility has a capacity of 112 beds. At the time of the survey the census was 100. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	1. DOOR HAS BEEN REPARIED ON 06/12/14 AND IS NOW LATCHING PROPERLY. 2. ALL DOORS AT CENTER HAVE BEEN CHECKED AND ARE ALL FUNCTIONING CORRECTLY. 3. MAINTENANCE DIRECTOR HAS BEEN EDUCATED ON PROPER DOOR CLOSURE AND LATCHING. 4. MAINTENANCE DIRECTOR TO AUDIT 30 DOORS PER WEEK FOR PROPER FUNCTIONING. RESULTS OF AUDITS WILL BE REVIEWED AT QPI.	08/04/14

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not have a corridor door that meets the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents within the smoke compartment. Findings include: On facility tour between 09:30 AM and 01:30 PM on 06/11/2014, it was observed that the corridor door to the 3rd floor Resident room 311, did not close and latch properly into the frame when tested. This deficient practice was verified by the Maintenance Director (JJ), at the time of discovery.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	1. DOOR HAS BEEN REPAIRED ON 06/12/14 AND IS NOW LATCHING PROPERLY. 2. ALL DOORS AT CENTER HAVE BEEN CHECKED AND ARE ALL FUNCTIONING CORRECTLY. 3. MAINTENANCE DIRECTOR HAS BEEN EDUCATED ON PROPER DOOR CLOSURE AND LATCHING. 4. MAINTENANCE DIRECTOR TO AUDIT 30 DOORS PER WEEK FOR PROPER FUNCTIONING. RESULTS OF AUDITS WILL BE REVIEWED AT QPI.	08/04/14

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 09:30 AM and 01:30 PM on 06/11/2014, it was observed that the corridor door to the 1st floor Kitchen from the dining area, did not automaticaly close and latch properly into the frame when tested. This deficient practice was verified by the Maintenance Director (JJ), at the time of discovery.	K 029		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5170

June 30, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5340023

Dear Mr. Thompson:

The above facility was surveyed on June 9, 2014 through June 12, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File