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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 72QM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**
2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GALEON**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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 **01/11/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (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
	40			
(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):
This is to inform you that Galeon (Community Memorial Home), Osakis MN, 245465, is requesting a continuing annual waiver for K- K521. Refer to the CMS 2567 for justification. Document will be forwarded to CMS. We recommending that CMS approve this annual waiver request.

17. SURVEYOR SIGNATURE Date:
Kathleen Lucas, Unit Supervisor 01/18/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 01/18/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/07/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2019

Administrator
Galeon
410 West Main Street
Osakis, MN 56360

RE: Project Number S5465030

Dear Administrator:

On December 13, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 29, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 17, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 17, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 8, 2019. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard completed on November 29, 2018, effective January 8, 2019 and therefore remedies outlined in our letter to you dated December 13, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2019

CMS Certification Number (CCN): 245465

Administrator
Galeon
410 West Main Street
Osakis, MN 56360

Dear Administrator:

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

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

Effective January 8, 2019 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 72QM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GALEON**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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 **11/29/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

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

X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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):

This is to inform you that Galeon (Community Memorial Home), Osakis MN, 245465, is requesting a continuing annual waiver for K- K521. Refer to the CMS 2567 for justification. Document will be forwarded to CMS. We recommending that CMS approve this annual waiver request.

17. SURVEYOR SIGNATURE — Date:
Rachel Adams, HFE NE II — 12/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 01/07/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 13, 2018

Administrator
Galeon
410 West Main Street
Osakis, MN 56360

RE: Project Number S5465030

Dear Administrator:

On November 29, 2018, a standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 8, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by March 1, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by May 29, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/26/18 through 11/29/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/26/18 through 11/29/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		1/8/19

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

Electronically Signed | 12/19/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

(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 580	Continued From page 1 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

(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 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to notify the physician of a newly acquired pressure ulcers for 1 of 5 residents (R18) reviewed for pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) dated 4/19/2018, identified R18 was moderately cognitive impaired. R18 required extensive assistance for transferring, toileting, bed mobility, dressing, personal hygiene. R18 had no pressure ulcers. R18 was at risk for pressure ulcers R18's quarterly MDS, dated 10/4/18, indicated R18 had no pressure ulcers, but was at risk. Interventions included a pressure reducing mattress and wheelchair cushion. R18's Comprehensive Skin Assessment, dated 10/3/18, indicated R18 had no pressure ulcers. R18 was at moderate risk for pressure ulcer development. R18 did not have redness over bony prominences after 2 hours of sitting/laying. Interventions included 2 hour repositioning. A Progress Note dated 11/18/18, indicated R18 to had an open area to the lower buttocks measuring 0.3 centimeters (cm) x 0.5 cm. Additionally, a wide slit measuring 2.5 cm x 1 cm to the right gluteal fold. Areas were cleansed and registered nurse notified. A Wound Assessment/Monitoring form, dated	F 580	F 580 R18 was determined to be affected by the deficient practice. The facility failed to ensure that the residents□ physician was notified of a newly acquired pressure ulcer. All residents may be affected by this deficient process. All professional nursing staff completed one on one education regarding the need to notify the MD regarding any change in condition including a pressure ulcer from 12/11-12/19/18. Education r/t pressure ulcer interventions and prevention for nurse□s will be on January 3, 2019. Policy/procedure was reviewed and updated regarding notification of physician for a pressure ulcer. New checklist of what to do when a pressure ulcer is found will be started. Audits will be completed by DNS or designee 3x per week for one month, then 2x per week for one month, and then 1x per week for one month that the MD was notified of any new pressure ulcers and interventions are in place and are being followed. Thereafter the DNS or designee will monitor to ensure compliance monthly. Results will be discussed at Quality Assurance Meeting held March 19, 2019. Corrective action will be completed by January 8, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

(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 580	Continued From page 3 11/18/18, idenfied the areas as stage 2 (partial thickness loss of skin presenting as a shallow open ulcer with a red/pink wound bed) pressure ulcers. Scant amount of bleeding from both areas and no signs of infection. Protective ointment applied. Interventions included to have R18 lay down twice daily, apply protective ointment to the areas, and to ensure the elastic from the incontinent brief was not on the areas. A Wound Assessment/monitoring form, dated 11/23/18, identified 3 pressure ulcers, all at a stage 2. 1. Left gluteal fold measured 0.2 cm x 4 cm x 0.1 cm. 2. Left gluteal fold measured 0.3 cm x 0.7 cm x 0.1 cm. 3. right gluteal fold measured 0.2 cm x 2.5 cm x 0.1 cm. wound bed pink with no signs or symptoms of infection. No drainage. Area cleansed and protective cream applied. R18's medical record lacked physician notification and treatment orders for the pressure ulcers. Standing orders direct wounds and skin breakdown will be managed in compliance with skin protocols unless the resident has other medical orders. "*in all cases, the physician will be contacted for all continued problems." During observation at 1:22 p.m. on 11/29/18, registered nurse (RN)-A assessed R18's pressure ulcers. R18's had no open areas to the buttocks. RN-A stated the areas were healed as of today. The skin was pink and blanchable. During an interview at 1:27 p.m., on 11/29/18 RN-A stated the 2-stage 2 pressure ulcers were identified and assessed on 11/18/18. RN-A stated	F 580		

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	245465	A. BUILDING _____ B. WING _____	11/29/2018

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F 580	Continued From page 4 the ulcers were a result of pressure from the incontinent brief. RN-A stated she verbally reported to the aides to apply protective ointment to the areas more frequently and encourage R18 to lay down twice daily. RN-A stated the physician was not notified of the pressure ulcer development. RN-A stated the physician is to be notified when a pressure ulcer is identified. RN-A stated the physician was not notified of the pressure ulcer development and wound orders were not obtained as it was the weekend and missed. During an interview at 2:07 p.m. on 11/29/18, the director of nursing (DON) stated nursing assistants inform the nurse when skin changes. The nurse then completes an assessment and notifies the physician for treatment orders. A facility policy Wound Management/Skin Integrity/Ulcers, dated 11/9/15, indicated treatment/management of resident who have a loss of skin integrity will receive the appropriate treatment/services which may include specific physician ordered medication/treatment. A policy related to physician notification was requested and not provided.	F 580		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		1/8/19

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F 686	Continued From page 5 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement intervention of timely repositioning to prevent and heal a pressure ulcer for 1 of 5 residents (R18) reviewed for pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) dated 4/19/2018, identified R18 was moderately cognitively impaired. R18 required extensive assistance for transferring, toileting, bed mobility, dressing, personal hygiene. R18 had no pressure ulcers. R18 was at risk for pressure ulcers R18's quarterly MDS, dated 10/4/18, indicated R18 had no pressure ulcers, but was at risk. Interventions included a pressure reducing mattress and wheelchair cushion. R18's Comprehensive Skin Assessment, dated 10/3/18, indicated R18 had no pressure ulcers. R18 was at moderate risk for pressure ulcer development. R18 did not have redness over bony prominences after 2 hours of sitting/laying. Interventions included 2 hour repositioning. R18's care plan dated 10/29/18, identified a pressure reducing mattress and wheelchair cushion. The care plan indicated R18 was able to	F 686	F686 R18 was determined to be affected by the deficient practice. The facility failed to reposition R18 timely (every 2 hours) to prevent and heal a pressure ulcer, did not notify R18□s MD of the pressure ulcer, nor did the care plan have updates r/t development of the pressure ulcer or new interventions to heal and prevent pressure ulcers. All residents may be affected by this deficient process. All professional nursing staff completed one on one education from 12/11--12/19/18 regarding the need to reposition residents every 2 hours or when designated on the careplan to prevent the development of pressure ulcers or if a resident has a pressure ulcer to help heal the pressure ulcer; and to notify the MD regarding any change in condition including a pressure ulcer, updating the care plan with interventions and informing nursing staff of these updates. A new checklist for when a pressure ulcer/wound is found will be initiated which includes doing audits for turning and repositioning with sticky notes. Further education r/t pressure ulcer interventions/ prevention and care planning for nurse□s will be on January 3, 2019. Policy/procedure was reviewed and	

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F 686	Continued From page 6 turn and reposition self in bed. The care plan directed staff to remind and assist R18 to reposition every 2 hours and required assistance of 1 to 2 staff for repositioning. A Progress Note dated 11/18/18, indicated R18 had an open area to the lower buttocks measuring 0.3 centimeters (cm) x 0.5 cm. Additionally, a wide slit measuring 2.5 cm x 1 cm to the right gluteal fold. Areas were cleansed and registered nurse notified. A Wound Assessment/Monitoring form, dated 11/18/18, idenfied the areas as stage 2 (partial thickness loss of skin presenting as a shallow open ulcer with a red/pink wound bed) pressure ulcers. Scant amount of bleeding from both areas and no signs of infection. Protective ointment applied. Interventions included to have R18 lay down twice daily, apply protective ointment to the areas, and to ensure the elastic from the incontinent brief was not on the areas. A Wound Assessment/monitoring form, dated 11/21/18, identified both pressure ulcers remained at a stage 2. Measurements remained unchanged. Scant bleeding at both areas. Protective ointment applied. Areas are superficial. Wound beds are clean and pink. No signs or symptoms of infection. A Wound Assessment/monitoring form, dated 11/23/18, identified 3 pressure ulcers, all at a stage 2. 1. Left gluteal fold measured 0.2 cm x 4 cm x 0.1 cm. 2. Left gluteal fold measured 0.3 cm x 0.7 cm x 0.1 cm. 3. right gluteal fold measured 0.2 cm x 2.5 cm x 0.1 cm.	F 686	updated regarding notification of physician for a pressure ulcer. Audits will be completed by DNS or designee 3x per week for one month, then 2x per week for one month, and then 1x per week for one month that the MD was notified of any new pressure ulcers, that the care plan was updated with new interventions and repositioning done as per care plan. Further education on the importance of repositioning will be completed with NAR□s on January 2, 2019 and for nurses on January 3, 2019. Results will be discussed at Quality Assurance Meeting held in March 19, 2019. Corrective action will be completed by January 8, 2019.	

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wound bed pink with no signs or symptoms of infection. No drainage. Area cleansed and protective cream applied.

R18's care plan lacked updates related to the development of the pressure ulcers or new interventions to heal and prevent pressure ulcers.

R18's medical record lacked physician notification of the pressure ulcer or orders for treatment.

During continuous observations starting at 10:14 a.m. on 11/29/18, the following was observed.
-10:14 a.m. R18 was in the activities room, sitting in a wheelchair. A black cushion was in the wheelchair.
-11:00 a.m. exercise technician (ET)-A moved R18 to the television room. ET-A did not offer or provide repositioning.
-11:31 a.m. ET-A moved R18 to the dining room for lunch. ET-A did not offer or provide repositioning.
-12:24 a.m. licensed practical nurse (LPN)-B assisted R18 to her room. LPN-B did not offer or provide repositioning.
12:41 a.m. LPN-B applied Apercream to R18's knees and shoulders. LPN-B did not offer or provide repositioning.
No staff offered or repositioned R18 between 10:14 a.m. and 1:05 a.m. (2 hours and 51 minutes).
At 1:08 p.m. surveyor approached nursing assistant (NA)-B and nursing assistant (NA)-C. Both stated they follow the resident's care plan/kardex located in each resident bathroom. Additionally all residents are repositioned every 2 hours unless the kardex directs differently. Both NA's stated they were done repositioning all but one resident after lunch. The remaining resident

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was not R18. Both NA's stated R18 is repositioned every 2 hours. When asked the last time R18 was repositioned both stated R18 was to be repositioned at noon, but was not.
-1:15 p.m. NA-B and NA-C toileted R18 with a sit/stand lift, then used the sit/stand lift to lay R18 in bed.
-1:22 p.m. registered nurse (RN)-A assessed R18's pressure ulcers. R18's had no open areas to the buttocks. RN-A stated the areas were healed as of today. The skin was pink and blanchable.

During an interview at 1:27 p.m. on 11/29/18, RN-A stated the 2, stage 2 pressure ulcers were identified and assessed on 11/18/18. RN-A stated the ulcers were a result of pressure from the incontinent brief. RN-A stated she verbally reported to the aides to apply protective ointment to the areas more frequently and encourage R18 to lay down twice daily. RN-A stated the physician was not notified of the pressure ulcer development. RN-A stated the physician is to be notified when a pressure ulcer is identified. RN-A stated the physician was not notified of the pressure ulcer development and wound orders were not obtained as it was the weekend and missed. RN-A stated staff are to assist with repositioning every 2 hours.

During an interview at 2:07 p.m. on 11/29/18, the director of nursing (DON) stated nursing assistants inform the nurse when skin changes occur. The nurse then completes an assessment and notifies the physician for treatment orders. The DON stated staff are to follow the resident's care plan.

A facility policy Wound Management/Skin

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F 686	Continued From page 9 Integrity/Ulcers, dated 11/9/15 indicated "all residents are preventatively placed on pressure reduction mattresses and cushions in wheelchairs based on the skin assessment. Those residents who represent a high risk will have futher preventative interventions put in place. Appropriate turning and repositioning schedules will also be put in place per assessment. An initial/immediate care plan will be initiated." "Residents with risk for or who have a loss of skin integrity will receive the appropriate treatment/services, and residents who are determined to be at risk for or who have loss of skin integrity will receive the appropriate treatment/services which may include." Specific physican ordered medication/treatment. Repositioning or "off-loading" as per resident assessment and care plan.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and	F 693		1/8/19

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F 693	Continued From page 10 services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess gastrostomy tube placement for 1 of 1 residents (R30) prior to administering medications. Findings include: R30's admission Minimum Data Set (MDS), dated 8/30/18, indicated R30 received nutrition via a feeding tube. During observations at 7:57 a.m. on 11/28/18, licensed practical nurse (LPN)-A prepared seven medications for R30 by crushing the medication individually and placing the medication in seven separate medication cups. LPN-A mixed 10 cc of tap water to each of the medication cups. LPN-A put air in a 60 cc syringe and attached the syringe to R30's gastrostomy tube (G-tube). LPN-A opened the clamp. LPN-A pushed on the syringe plunger, administering air through the G-tube, while listening with a stethoscope on the abdomen near the tube insertion site. LPN-A clamped the tube and removed the syringe. LPN-A did not pull back on the syringe to check for gastric contents. LPN-A administered 60 cc's of tap water via G-tube, prior to administering each medication individually via gravity, flushing with 10 cc of tap water between all medications. LPN-A flushed the G-tube with 60 cc of tap water once all medication were administered and clamped the G-tube.	F 693	F693 R 30 was determined affected by the deficient practice. The facility failed to ensure that staff appropriately followed a physician order which directed to check proper tube placement before medication, fluids or feeding by inserting 10 cc□s of air and auscultating, then removing the air and then checking gastric residual. All residents, who have a feeding tube, could be affected by this deficient process. All professional nurses completed one on one education regarding this with the DNS between 12/11□12/19/18. Audits will be done 4 times weekly for a month on alternating shifts, then 3 times weekly for a month, and then 2 times weekly for a month by DNS or designee, to make sure MD orders were followed and documented on TAR that both auscultation and gastric residual volume were done. DNS updated policy/procedure for confirming placement of the feeding tube to state to follow MD orders and the procedure for air insertion/removal steps and checking gastric residual volume. Nurse□s meeting on January 3, 2019 as follow up. Results will be discussed at Quality Assurance Meeting held March 19, 2019. Corrective action will be completed by January 8, 2019.	

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Upon completion of medication administration LPN-A stated she did not use any other method for checking G-tube placement other than auscultation (listening).

R30's physician orders identified an order dated 11/15/18, which directed to check proper tube placement before medication, fluids and feedings. Check placement of tube by inserting 10 cc of air and auscultate (listen). Then remove 10 cc of air. Check for gastric residual.

During an interview at 2:06 p.m., on 11/29/18 the director of nursing (DON) stated facility's practice is to check placement of G-tube by auscultation of air. The DON went onto say staff are to follow physician orders.

The facility's policy Confirming Placement of Feeding Tubes, undated, indicated the purpose of this procedure is to ensure proper placement of the feeding tube to prevent aspiration during feedings.
"To Confirm Placement of Tube:
1. Observe for change in the external tube length marked at the time of the initial insertion X-ray.
2. Observe for signs of respiratory distress (if applicable).
3. Observe for changes in residual volume:
a. A sharp increase in residual volume may indicate that a small bowel tube has moved into the stomach;
b. Little to no residual volume may suggest that the tube has migrated from the stomach to the esophagus..
4. If feeding has been interrupted for a few hours, observe (nasogatric, gastric, jejunostomy tubes):
a. Fasting stomach contents will have a clear,

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F 693	Continued From page 12 colorless or green appearance. b. Respiratory secretions may look similar to gastric contents. c. Post-pyloric/intestinal contents cam be bile-stained, light to dark yellow or greenish-brown. 5. If the above suggests improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician..."	F 693		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		1/8/19

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F 880	Continued From page 13 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a comprehensive infection control program to include day to day tracking of signs and symptoms of infections not requiring antibiotics, this had the potential to affect all 35 residents. In addition, the facility failed to follow proper hand hygiene practice for one of one residents (R29) and failed to disinfect the same residents glucometer when checking a residents blood sugar. And failed to follow proper hand hygiene for 1 of 3 residents (R14) when providing personal care. Findings include: The facilities infection control data from September 2018, October 2018 and November 2018 identified the following information: The facilities infection control line by line log for September 2018, October 2018 and November 2018 indicated areas to document resident name, admit date, room number, body system of infection, dates of symptoms, types of symptoms, collection date, type of test, specimen source, results, and antibiotics. However, did not include an area to track illness or symptoms of infection that did not require antibiotic treatment. Although the facility line by line infection control logs identified all the required areas for infections requiring antibiotics, the facility failed to track infections not requiring antibiotics. During interview on 11/29/18, at 10:33 a.m. registered nurse (RN)-A stated the facility does	F 880	F880 The facility failed to implement a comprehensive infection control program to include day to day tracking of signs and symptoms of infections not requiring antibiotics which has the potential to affect all residents and in addition, the facility failed to follow proper hand hygiene after pericare and performing a blood sugar check, or to disinfect a residents glucometer after checking a residents blood sugar. The Hand hygiene and glucometer cleaning disinfecting policies/procedures were reviewed and updated by the DNS. One on one instruction with all the professional nurses were completed 12/11-12/19/18 regarding the cleaning of the glucometer and hand hygiene after completing a blood glucose check and cleansing the glucometer. Audits will be done 2x/day□once on day shift and once on pm shift 4 days/week for 4 weeks, then 3 times/week for 4 weeks, then 2 times /week for 4 weeks by the DNS or designee. Audits will be completed on nursing staff doing perineal /incontinence care 4 days per week for one month (2 staff on days, 2 staff on PM□s) ; then 3 days per week for one week (2 staff on days, 2 staff on PM□s) and then 2 days per week for one month (2 staff on days, 2 staff on PM□s by the DNS or designee. A new policy/procedure was initiated on 12/19/18 regarding the day to day tracking of signs/symptoms of infections not requiring antibiotics including a tracking form. Professional	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 not have a system in place for documenting non antibiotic signs, symptoms or illnesses. RN-A stated all non antibiotic illness and symptoms are all reported verbally during report each morning. RN-A stated non antibiotic illness are not tracked. Rn-A stated she is known as the infection control preventionist in the facility but she was not certified and has not trended or tracked any residents if they are not on an antibiotic. The facility policy, dated 2015, titled Infection Control Program indicated the infection control program exits to assure a safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. R29's Minimal Data Set MDS dated, 10/25/18 indicated R29 was diagnosed with diabetes mellitus and received insulin injections. On 11/27/18, at 10:59 a.m. licensed practical nurse (LPN)-C was observed to gather the glucometer, a blood glucose strip, lancet and gloves and entered R29's room. LPN-C washed her hands and donned gloves. LPN-C swabbed R29's finger with an alcohol wipe, after it was dry, used the lancet to poke R29's finger, placed the glucose strip in the glucometer and obtained a sample of R29's blood. LPN-C gave R29 a cotton ball for his finger, LPN-C placed the lancet and the used glucose strip into a plastic Dixie cup. LPN-C doffed her gloves, did not wash her hands and grabbed the plastic Dixie cup opened R29's door and proceeded back to the medication cart. LPN-C disposed of the used lancet into the sharps container on the medication cart. LPN-C unlocked the medication cart and placed the	F 880	nurses were instructed how to use the tracking forms. Audits will be done by the DNS, Infection Preventionist or designee 3x per week for one month, 2x per week for one month and then 1x per week for one month to make sure that the tracking form is used for residents who display symptoms such as cough, fever, emesis, diarrhea, and rashes without antibiotic use. Education on hand hygiene following pericare will be on January 3, 2019 for the NARs and for the Nurses on all the above issues on January 2, 2019. Results will be discussed at Quality Assurance Meeting held March 19, 2019. Corrective action will be completed by January 8, 2019.	

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	245465	A. BUILDING _____ B. WING _____	11/29/2018

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F 880	Continued From page 16	F 880		

glucometer in a basket with R29's insulin pens, locked the medication cart then used hand sanitizer. LPN-C indicated she did not think the glucometer needed to be wiped down after each use since R29 was the only one using it. LPN-C stated she was not aware if there was a policy for cleaning the glucometer. LPN-C did state she should have used hand sanitizer after glove removal.

When interviewed on 11/27/18, at 2:57 p.m. the director of nursing (DON) stated technically the glucometer is designated for that one individual, they would only need to clean it if visible with blood. DON stated there is a cleaning policy, but couldn't remember what kind of wipe they are suppose to use. The DON went on to say the nurses and certified nursing assistants have hand sanitizer available to them, hand hygiene needs to be completed after removing gloves.

The Glucometer Cleaning and Disinfecting Policy/Procedure dated 11/16 indicated it is the facilities policy to clean and disinfect the blood glucose meters after each use.

R14's quarterly Minnimum Data Set (MDS), dated 10/9/2018, included diagnosis of dual sensory (hearing and vision) impairment and developmental disorder of speech and language. The MDS also identified R14's cognition could not be assessed, however, long and short term memory were intact. Also included in the MDS, R14 required extensive assistance with toileting and personal hygiene, was frequently incontinent of urine, and always continent of stool.

During an observation on 11/28/18, at 8:33 a.m.

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F 880	Continued From page 17	F 880		

nursing assistant (NA)-C assisted R14 back to her room, from the dining room, via wheelchair. NA-C locked the wheels of the wheelchair and placed a transfer belt around R14's waist. R14 stood up and then pivoted to sit on the toilet with guidance provided by NA-C. NA-C assisted R14 with pulling down pants and brief. R14 made a low throaty sound until the transfer belt was removed. R14 sat on the toilet and stood up when finished. NA-C gloved right hand and used pre-moistened cloth to wipe R14's bottom. NA-C removed the glove, and disposed it into the trash. NA-C assisted R14 with pulling up brief, and placed a transfer belt around R14's waist. R14 made verbal noises and NA-C stepped back, which allowed R14 to wash her hands at the sink. R14 pulled a paper towel to dry hands and reached to drop it in the wastebasket but missed. NA-C picked up the used paper towel with a bare hand and placed it in the trash. Without performing hand hygiene, NA-C assisted R14 to walk to the recliner. R14 pivoted and pulled on the transfer belt until NA-C removed it. R14 adjusted clothing and sat down. NA-C ensured R14 had the call light and, without performing hand hygiene, NA-C walked out of R14's room and headed down the hall toward unit 100 to answer a call light. NA-C walked into the resident's room and touched the resident's shoulder and arm of wheelchair when she spoke. NA-C was stopped and asked to step into the hallway.

When interviewed on 11/28/18, at 8:51 a.m. NA-C indicated that hand hygiene should be performed when removing gloves, however, stated that she had not done so after removing her glove after doing peri-care for R14, and verified that R14 had a bowel movement. NA-C immediately left to

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F 880	Continued From page 18 wash her hands. The Hand Hygiene Policy undated, indicated hand hygiene must be performed immediately after gloves are removed.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions 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 documentation review the facility failed to ensure a residents wheel chair was clean and sanitary for 1 of 1 residents (R30) reviewed for environment. Findings include: R30's admission Minimum Data Sets (MDS) dated 8/30/18, indicated R30 had severely impaired cognition, hypertension (elevated blood pressure), dysphasia (inability to communicate), quadriplegia (paralysis of all 4 limbs), and had a gastrostomy (surgical opening into the stomach) for feedings and medications. R30 required a wheel chair for mobility with staff to propel to all locations. R30's physician's orders dated 10/19/18, indicated R30 was to have nothing by mouth, all feedings and medications by gastrostomy site. During observation on 11/28/18, when observing R30's wheel chair, it was noted to have the appearance of food, dirt and a cream/white	F 921	F921 R30 was determined to be affected by the deficient practice. The facility failed to ensure that R30□s wheelchair was not clean and sanitary. All residents who use a wheel chair could be affected by this deficient process. All nursing staff will be informed of the wheelchair washing schedule and documentation required to verify that wheel chairs were cleaned by the DNS, Maintenance Director or designee. The Medical Equipment Maintenance/Nursing policy/procedure for wheelchair washing was updated. Audits will be done 4 times weekly on night shift for a month, then 3x per week the next month, and then 2 times weekly for a month to check that wheel chairs are washed daily as per schedule by DNS or designee. NAR education will be on January 2, 2019 and Nurse□s education on January 3, 2019. Results will be discussed at Quality Assurance Meeting held in March 19, 2019. Corrective action	1/8/19

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F 921	Continued From page 19 substance on the wheels, spokes and frame. During observation on 11/29/18, at 9:00 a.m. R30's wheel chair continues to have cream/white substance on the wheels, spokes and frame, along with chunks of food particles in several different places on frame of wheel chair. During interview on 11/29/18, at 10:16 a.m. nursing assistant (NA)-D stated the night shift staff clean the wheel chairs and they have a schedule, although she does not know what their schedule is. NA-D stated they should be cleaning all parts of the wheelchair. NA-D stated R30's wheel chair is not clean and can see food particles, dirt and milk on the tires and both sides of the wheel chair. NA-D stated the wheel chair needs to be cleaned. During interview on 11/29/18, at 10:22 a.m. licensed practical nurse (LPN)-A stated the wheel chairs are supposed to be cleaned weekly on night shift. LPN-A stated the chair is not clean as she could see some kind of food, and white stuff like dried milk all over the wheels and wheelchair spokes. LPN-A stated R30's wheel chair needs to be cleaned. LPN-A removed R30's wheel chair from his room and brought it to an area for house keeping to be cleaned. During interview on 11/29/18 at 10:29 a.m. registered nurse (RN)-A stated R30's wheel chair is not clean as she saw white substance and food particles on wheel, spokes and frame of wheel chair. RN-A stated its horrible and needs to be cleaned. The facilities Weekly Wheelchair Washing Schedule was obtained and R30's wheelchair	F 921	will be completed by January 8, 2019.	

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F 921	Continued From page 20 was scheduled to be cleaned on Monday nights. Documentation verifying R30's wheelchair was cleaned per the schedule was requested but not received. A facility policy for Medical Equipment Maintenance/Nursing Policy and Procedure dated 10/2017, indicates all equipment used for patient care will function properly and safely by inspecting, maintaining, and cleaning medical equipment on a routine basis.	F 921		

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 1963 and 1977 sections of Community Memorial Home were found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. and the 2012 edition of NFPA 99, Health Care Facilities Code.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/19/2018

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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By e-mail to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

This facility was surveyed as one building. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. In 2008 a 2 story Wellness Center was added.
As of Nov 1, 2016 all sections are considered existing and were surveyed as one building.

The building is fully fire sprinkler throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The resident rooms have battery operated smoke detectors.

The facility has a capacity of 40 beds and had a census of 36 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by;	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of residents. Findings include:	K 353	K353 Ceiling tile was put back into place on 11/29/18. Prior to and after completion of any work completed in the ceiling the Director of Environmental Services or his designee will ensure that all ceiling tiles be put back into place prior to leaving work area. When completing weekly safety checks the Maintenance Assistant will observe all ceiling areas to ensure all tiles are in place. The Director of Environmental Services will complete	1/8/19

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K 353	Continued From page 3 During the facility tour between 8:00 am to 11:30 am on 11/29/2018 observations revealed a ceiling tile missing in the Wellness Center corridor on the 2nd floor. This deficient condition was confirmed by the Environmental Service Director.	K 353	weekly audits for one month to ensure that the sprinkler system is being maintained and in safe working order.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire	K 363		1/8/19

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K 363	Continued From page 4 window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the protection of one fire rated opening in the means of egress in accordance with NFPA 101 (12) The Life Safety Code section 8.3.3.1 and NFPA 80 (11) section 6.4.4.3.3. This deficient condition could allow for the spread of fire or smoke into the corridors restricting the means of egress affecting 12 of the 40 residents. Findings include: During the facility tour between 8:00 am to 11:30 am on 11/29/2018 observations revealed the door in the fire barrier separating the apartments did not have a means to positively latch in a fire event. This deficient condition was confirmed by the Environmental Service Director.	K 363	K363 Door latching system will be replaced by Midwest Lock and Door Inc. by December 28th, 2018. Fire Door audit form was made. All fire doors will be inspected annually by the Director of Environmental Services. The Administrator will ensure completion by signing off on annual audit form.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K 374		1/8/19

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K 374	Continued From page 5 Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 4 smoke barrier doors in accordance with the Life Safety Code (NFPA 101) 2012 edition section 101.8.5.4.1 and NFPA 80 the Standard for Fire Doors and Other Opening Protective's, 2010 edition, section 6.3.1.7. This deficient practice could allow the transfer of smoke from one smoke compartment to another making the corridors untenable. This condition could affect all of the 40 residents and an undetermined amount of staff and visitors. Findings include: During the facility tour between 8:00 am to 11:30 am on 11/29/2018 observations revealed; 1. The cross corridor doors for all the resident wings have astragals and did not have door coordinators to allow for proper closing. 2. The cross corridor doors to the Wellness Center had a center door gap that exceeded 1/8 inch. This deficient condition was confirmed by the Environmental Service Director.	K 374	K374 1. Received quote for bar type door coordinators to be installed. Have scheduled this to be completed by Midwest Lock and Door Inc. Date scheduled for completion by December 28th, 2018. Fire Door audit form was made. All fire doors will be inspected annually by the Director of Environmental Services. The Administrator will ensure completion by signing off on annual audit form. 2. To ensure door gap will not exceed 1/8th inch fire resistant weather stripping will installed by authorized door company listed above before December 28th, 2018. The fire resistant weather stripping will be added to above fire door audit which again will be completed by the director of environmental services and signed off by the administrator annually.	

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GALEON	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

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K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: During the facility tour between 8:00 am to 11:30 am on 11/29/2018 observations revealed that the HVAC systems for all wings in the 1963 and 1977 additions have ducted air supply to the corridors and hot water baseboard heat in the resident rooms. There are no return air ducts in the resident rooms and the corridor is being used as a return plenum. This deficient condition was confirmed by the Director of Environmental Services .	K 521	K 521 A waiver continuation for K521 has been requested for which justification dated 12-4-18 on form CMS 2786R was attached.	1/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALEON	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

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K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to conduct inspections of all fire rated doors and required by NFPA 101 (12) Life Safety Code, section 7.2.1.15.2 & 7.2.1.15.4. This deficient practice could allow for the spread of fire if the doors were not maintained in accordance with its rating. This could affect all 40 residents and an undetermined amount of staff and visitors. Findings include: During the facility tour between 8:00 am to 11:30 am on 11/29/2018, documentation review revealed there was no record of fire rated door inspections. This deficient condition was confirmed by the Environmental Service Director.	K 761	K761 Inspection form was created to complete annual audit for fire doors and other opening protectives. This includes non-rated doors including corridor doors to patient rooms and smoke barrier doors. Per 7.2.1.15.7 items 1-11 will be verified by the Environmental Services Director. Audit was will be completed on or before 12/21/18 by the Environmental Services Director. The administrator will ensure completion by signing off on annual audit form.	1/8/19
K 901	Fundamentals - Building System Categories	K 901		1/8/19

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	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 901 SS=F	Continued From page 8 CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect all residents, as well as an undetermined amount of staff, and visitors. Findings include: During the facility tour between 8:00 am to 11:30 am on 11/29/2018, documentation review revealed there was no risk assessment completed at the time of the survey. This deficient condition was confirmed by the Environmental Service Director.	K 901	K901 The NFPA 99 risk assessment was initiated on 11/30/18 and will be completed on or before 12/21/18. The risk assessment will be reviewed annually by the Director of Environmental Services and the facility Administrator. This assessment will be made available to the Fire Marshal upon request and also placed in survey book.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		1/8/19

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K 914	Continued From page 9 locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to inspect and test the electrical receptacles in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect all 40 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: During the facility tour between 8:00 am to 11:30 am on 11/29/2018, documentation review revealed there was no record of the testing of receptacles in resident care areas. This deficient condition was confirmed by the Environmental Service Director.	K 914	K914 Inspection form was created to complete annual audit for electrical receptacles. Audit of all rooms and areas in nursing home will be checked. Will be completed on or before 12/21/18 by the Environmental Services Director. The administrator will ensure completion by signing off on annual audit of electrical receptacles.	

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K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to limit the use of extension cords as stated in NFPA 70 sections 400.8 & 590.3 item d. This deficient practice could affect an undetermined amount of residents. Findings include: During the facility tour between 8:00 am to 11:30 am on 11/29/2018, observations revealed an extension cord in resident room 108 was being	K 920	K920 Extension Cord was removed immediately from the resident room. Environmental Services completed a facility walk thru on 11/30/18 to inspect all areas to ensure that there were no extension cords in the facility. Housekeeping staff will complete weekly rounds in each resident room and area in the facility for one month to inspect for extension cords. Environmental Services Director will audit those finding weekly for	1/8/19

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K 920	Continued From page 11 used in place of permanent wiring. This deficient condition was confirmed by the Environmental Service Director.	K 920	one month.	

Name of Facility

Community Memorial Home at Osakis, MN Inc. dba Galeon

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K521 Heating, Ventilation and Air Conditioning (HVAC) equipment at CMH does not comply with LSC Chapter 19 and NFPA 90A, 2012 Edition because the corridors are used as a plenum.	A continuing waiver is being requested for K521 for the following reasons: A. An extreme financial hardship on Community Memorial Home (CMH) will result from compliance because: 1. 12-4-18 estimates for compliance (attached) with NFPA 90A show that it will cost between $552,007.00 and $751,085.00. Funding for this expense is not available under current reimbursement rules; 2. The electrical system at CMH would need to be modified at a cost that may exceed $56,094.00; 3. Asbestos abatement required during installation would cost between $73,6010.00 and $106,187.00; and 4. Non-complying systems are allowed to be used under LSC 9.2. B. If this waiver is approved, the safety of building occupants will not be compromised because: 1. CMH was built under Type II construction standards; 2. Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke; 3. CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13; 4. HVAC ventilation fans automatically shut down upon fire alarm activation or the detection of smoke; 5. Resident sleeping rooms are all equipped with single station battery operated smoke detectors; 6. The property of CMH is smoke and tobacco free with signs posted to that effect; 7. All CMH corridors are equipped with a compliant UL listed smoke detection system; 8. The local fire department is located 6 blocks away and will respond to an alarm in less than 10 mins; 9. CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and 10. A continuing waiver has been approved annually in the past for Community Memorial Home. Requested by: Angie R. Reinke, Administrator 12/17/18

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office MN State Fire Marshal	Date 12-19-2018

ra morton
CONSTRUCTION MANAGERS

3315 Roosevelt Road • Suite 100
St. Cloud, MN 56301
Bus 320.251.0262
Fax 320.251.5749
www.ramorton.com

December 4, 2018

Angie Reinke, Administrator
Galeon
410 West Main Street
Osakis, MN 56360

Dear Angie,

Per our conversation on Monday December 3, 2018, costs for complying with NFPA 90A are shown in the Preliminary Master Budget that is attached. Please consider the high and low ranges provided in the budget to be our current estimate of cost.

Thank you.

Sincerely,

Preston Euerle
President/CEO

PRELIMINARY MASTER BUDGET
Galeon - Community Memorial Home
PREPARED: 12/4/2018

CONSTRUCTION MANAGERS
"right from the start"
3315 Roosevelt Road, Ste. 100
St. Cloud MN 56301
Bus. (320) 251-0262 Fax: (320) 251-5749

	Low Range 24,000 S.F. DOLLARS		High Range 24,000 S.F. DOLLARS	
I. LAND				
SUBTOTAL LAND	$ -		$ -	
II. CONSTRUCTION COSTS				
GENERAL CONDITIONS	$ 32,818	$ 1.37	$ 42,070	$ 1.75
INTERIOR FINISHES / DEMO	$ 23,629	$ 0.98	$ 37,863	$ 1.58
MECHANICAL	$ 252,039	$ 10.50	$ 336,561	$ 14.02
FIRE SPRINKLER	$ 6,564	$ 0.27	$ 14,023	$ 0.58
ELECTRICAL	$ 45,945	$ 1.91	$ 56,094	$ 2.34
CONTINGENCY	$ 37,121	$ 1.55	$ 49,269	$ 2.05
SUBTOTAL CONSTRUCTION COSTS	$ 398,114	$ 16.59	$ 535,880	$ 22.33
III. SOFT COSTS				
FEES / PERMITS / PRINTING	$ 80,292	$ 3.35	$ 109,018	$ 4.54
OTHER	$ -	$ -	$ -	$ -
SUBTOTAL SOFT COSTS	$ 80,292	$ 3.35	$ 109,018	$ 4.54
IV. OWNER ITEMS				
FURNITURE/FIXTURES/EQUIPMENT	$ -		$ -	
OTHER - ASBESTOS ABATEMENT	$ 73,601	$ 3.07	$ 106,187	$ 4.42
SUBTOTAL OWNER ITEMS COSTS	$ 73,601	$ 3.07	$ 106,187	$ 4.42
V. TOTAL PROJECT COST	$ 552,007	$ 23.00	$ 751,085	$ 31.30

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	00109	A. BUILDING: _____ B. WING _____	11/29/2018

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GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 11/26/18 - 11/29/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		1/8/19

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, facility failed to notify the physician of a newly acquired pressure ulcers for 1 of 5 residents (R18) reviewed for pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) dated 4/19/2018, identified R18 was moderately cognitive impaired. R18 required extensive assistance for transferring, toileting, bed mobility, dressing, personal hygiene. R18 had no pressure ulcers. R18 was at risk for pressure ulcers R18's quarterly MDS, dated 10/4/18, indicated R18 had no pressure ulcers, but was at risk. Interventions included a pressure reducing mattress and wheelchair cushion. R18's Comprehensive Skin Assessment, dated 10/3/18, indicated R18 had no pressure ulcers. R18 was at moderate risk for pressure ulcer development. R18 did not have redness over bony prominences after 2 hours of sitting/laying. Interventions included 2 hour repositioning. A Progress Note dated 11/18/18, indicated R18 to had an open area to the lower buttocks measuring 0.3 centimeters (cm) x 0.5 cm. Additionally, a wide slit measuring 2.5 cm x 1 cm to the right gluteal fold. Areas were cleansed and registered nurse notified. A Wound Assessment/Monitoring form, dated 11/18/18, idenfied the areas as stage 2 (partial	2 265	Corrected	

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2 265	Continued From page 4	2 265		

thickness loss of skin presenting as a shallow open ulcer with a red/pink wound bed) pressure ulcers. Scant amount of bleeding from both areas and no signs of infection. Protective ointment applied. Interventions included to have R18 lay down twice daily, apply protective ointment to the areas, and to ensure the elastic from the incontinent brief was not on the areas.

A Wound Assessment/monitoring form, dated 11/23/18, identified 3 pressure ulcers, all at a stage 2. 1. Left gluteal fold measured 0.2 cm x 4 cm x 0.1 cm.
2. Left gluteal fold measured 0.3 cm x 0.7 cm x 0.1 cm.
3. right gluteal fold measured 0.2 cm x 2.5 cm x 0.1 cm.
wound bed pink with no signs or symptoms of infection. No drainage. Area cleansed and protective cream applied.

R18's medical record lacked physician notification and treatment orders for the pressure ulcers. Standing orders direct wounds and skin breakdown will be managed in compliance with skin protocols unless the resident has other medical orders. "*in all cases, the physician will be contacted for all continued problems."

During observation at 1:22 p.m. on 11/29/18, registered nurse (RN)-A assessed R18's pressure ulcers. R18's had no open areas to the buttocks. RN-A stated the areas were healed as of today. The skin was pink and blanchable.

During an interview at 1:27 p.m., on 11/29/18 RN-A stated the 2-stage 2 pressure ulcers were identified and assessed on 11/18/18. RN-A stated the ulcers were a result of pressure from the incontinent brief. RN-A stated she verbally

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2 265	Continued From page 5 reported to the aides to apply protective ointment to the areas more frequently and encourage R18 to lay down twice daily. RN-A stated the physician was not notified of the pressure ulcer development. RN-A stated the physician is to be notified when a pressure ulcer is identified. RN-A stated the physician was not notified of the pressure ulcer development and wound orders were not obtained as it was the weekend and missed. During an interview at 2:07 p.m. on 11/29/18, the director of nursing (DON) stated nursing assistants inform the nurse when skin changes. The nurse then completes an assessment and notifies the physician for treatment orders. A facility policy Wound Management/Skin Integrity/Ulcers, dated 11/9/15, indicated treatment/management of resident who have a loss of skin integrity will receive the appropriate treatment/services which may include specific physician ordered medication/treatment. A policy related to physician notification was requested and not provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures, conduct audits and provide education related to Notification of Change in resident health to ensure practioners are notified of changes in residents condition accurately. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 265		

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2 265	Continued From page 6 (21) days.	2 265		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement intervention of timely repositioning to prevent and heal a pressure ulcer for 1 of 5 residents (R18) reviewed for pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) dated 4/19/2018, identified R18 was moderately cognitively impaired. R18 required extensive assistance for transferring, toileting, bed mobility, dressing, personal hygiene. R18 had no pressure ulcers. R18 was at risk for pressure ulcers	2 900	Corrected	1/8/19

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2 900	Continued From page 7 R18's quarterly MDS, dated 10/4/18, indicated R18 had no pressure ulcers, but was at risk. Interventions included a pressure reducing mattress and wheelchair cushion. R18's Comprehensive Skin Assessment, dated 10/3/18, indicated R18 had no pressure ulcers. R18 was at moderate risk for pressure ulcer development. R18 did not have redness over bony prominences after 2 hours of sitting/laying. Interventions included 2 hour repositioning. R18's care plan dated 10/29/18, identified a pressure reducing mattress and wheelchair cushion. The care plan indicated R18 was able to turn and reposition self in bed. The care plan directed staff to remind and assist R18 to reposition every 2 hours and required assistance of 1 to 2 staff for repositioning. A Progress Note dated 11/18/18, indicated R18 had an open area to the lower buttocks measuring 0.3 centimeters (cm) x 0.5 cm. Additionally, a wide slit measuring 2.5 cm x 1 cm to the right gluteal fold. Areas were cleansed and registered nurse notified. A Wound Assessment/Monitoring form, dated 11/18/18, idenfied the areas as stage 2 (partial thickness loss of skin presenting as a shallow open ulcer with a red/pink wound bed) pressure ulcers. Scant amount of bleeding from both areas and no signs of infection. Protective ointment applied. Interventions included to have R18 lay down twice daily, apply protective ointment to the areas, and to ensure the elastic from the incontinent brief was not on the areas. A Wound Assessment/monitoring form, dated	2 900		

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2 900	Continued From page 8 11/21/18, identified both pressure ulcers remained at a stage 2. Measurements remained unchanged. Scant bleeding at both areas. Protective ointment applied. Areas are superficial. Wound beds are clean and pink. No signs or symptoms of infection. A Wound Assessment/monitoring form, dated 11/23/18, identified 3 pressure ulcers, all at a stage 2. 1. Left gluteal fold measured 0.2 cm x 4 cm x 0.1 cm. 2. Left gluteal fold measured 0.3 cm x 0.7 cm x 0.1 cm. 3. right gluteal fold measured 0.2 cm x 2.5 cm x 0.1 cm. wound bed pink with no signs or symptoms of infection. No drainage. Area cleansed and protective cream applied. R18's care plan lacked updates related to the development of the pressure ulcers or new interventions to heal and prevent pressure ulcers. R18's medical record lacked physician notification of the pressure ulcer or orders for treatment. During continuous observations starting at 10:14 a.m. on 11/29/18, the following was observed. -10:14 a.m. R18 was in the activities room, sitting in a wheelchair. A black cushion was in the wheelchair. -11:00 a.m. exercise technician (ET)-A moved R18 to the television room. ET-A did not offer or provide repositioning. -11:31 a.m. ET-A moved R18 to the dining room for lunch. ET-A did not offer or provide repositioning. -12:24 a.m. licensed practical nurse (LPN)-B assisted R18 to her room. LPN-B did not offer or provide repositioning.	2 900		

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2 900	Continued From page 9 12:41 a.m. LPN-B applied Apercream to R18's knees and shoulders. LPN-B did not offer or provide repositioning. No staff offered or repositioned R18 between 10:14 a.m. and 1:05 a.m. (2 hours and 51 minutes). At 1:08 p.m. surveyor approached nursing assistant (NA)-B and nursing assistant (NA)-C. Both stated they follow the resident's care plan/kardex located in each resident bathroom. Additionally all residents are repositioned every 2 hours unless the kardex directs differently. Both NA's stated they were done repositioning all but one resident after lunch. The remaining resident was not R18. Both NA's stated R18 is repositioned every 2 hours. When asked the last time R18 was repositioned both stated R18 was to be repositioned at noon, but was not. -1:15 p.m. NA-B and NA-C toileted R18 with a sit/stand lift, then used the sit/stand lift to lay R18 in bed. -1:22 p.m. registered nurse (RN)-A assessed R18's pressure ulcers. R18's had no open areas to the buttocks. RN-A stated the areas were healed as of today. The skin was pink and blanchable. During an interview at 1:27 p.m. on 11/29/18, RN-A stated the 2, stage 2 pressure ulcers were identified and assessed on 11/18/18. RN-A stated the ulcers were a result of pressure from the incontinent brief. RN-A stated she verbally reported to the aides to apply protective ointment to the areas more frequently and encourage R18 to lay down twice daily. RN-A stated the physician was not notified of the pressure ulcer development. RN-A stated the physician is to be notified when a pressure ulcer is identified. RN-A stated the physician was not notified of the pressure ulcer development and wound orders	2 900		

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2 900	Continued From page 10 were not obtained as it was the weekend and missed. RN-A stated staff are to assist with repositioning every 2 hours. During an interview at 2:07 p.m. on 11/29/18, the director of nursing (DON) stated nursing assistants inform the nurse when skin changes occur. The nurse then completes an assessment and notifies the physician for treatment orders. The DON stated staff are to follow the resident's care plan. A facility policy Wound Management/Skin Integrity/Ulcers, dated 11/9/15 indicated "all residents are preventatively placed on pressure reduction mattresses and cushions in wheelchairs based on the skin assessment. Those residents who represent a high risk will have futher preventative interventions put in place. Appropriate turning and repositioning schedules will also be put in place per assessment. An initial/immediate care plan will be initiated." "Residents with risk for or who have a loss of skin integrity will receive the appropriate treatment/services, and residents who are determined to be at risk for or who have loss of skin integrity will receive the appropriate treatment/services which may include." Specific physican ordered medication/treatment. Repositioning or "off-loading" as per resident assessment and care plan. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise if needed, policies and procedures, conduct audits and provide education related to pressure ulcer interventions to ensure interventions are in place and are being	2 900		

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2 900	Continued From page 11 followed. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess gastrostomy tube placement for 1 of 1 residents (R30) prior to administering medications. Findings include: R30's admission Minimum Data Set (MDS), dated 8/30/18, indicated R30 received nutrition via a feeding tube.	2 930	Corrected	1/8/19

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2 930	Continued From page 12 During observations at 7:57 a.m. on 11/28/18, licensed practical nurse (LPN)-A prepared seven medications for R30 by crushing the medication individually and placing the medication in seven separate medication cups. LPN-A mixed 10 cc of tap water to each of the medication cups. LPN-A put air in a 60 cc syringe and attached the syringe to R30's gastrostomy tube (G-tube). LPN-A opened the clamp. LPN-A pushed on the syringe plunger, administering air through the G-tube, while listening with a stethoscope on the abdomen near the tube insertion site. LPN-A clamped the tube and removed the syringe. LPN-A did not pull back on the syringe to check for gastric contents. LPN-A administered 60 cc's of tap water via G-tube, prior to administering each medication individually via gravity, flushing with 10 cc of tap water between all medications. LPN-A flushed the G-tube with 60 cc of tap water once all medication were administered and clamped the G-tube. Upon completion of medication administration LPN-A stated she did not use any other method for checking G-tube placement other than auscultation (listening). R30's physician orders identified an order dated 11/15/18, which directed to check proper tube placement before medication, fluids and feedings. Check placement of tube by inserting 10 cc of air and auscultate (listen). Then remove 10 cc of air. Check for gastric residual. During an interview at 2:06 p.m., on 11/29/18 the director of nursing (DON) stated facility's practice is to check placement of G-tube by auscultation of air. The DON went onto say staff are to follow physician orders.	2 930		

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2 930	Continued From page 13 The facility's policy Confirming Placement of Feeding Tubes, undated, indicated the purpose of this procedure is to ensure proper placement of the feeding tube to prevent aspiration during feedings. "To Confirm Placement of Tube: 1. Observe for change in the external tube length marked at the time of the initial insertion X-ray. 2. Observe for signs of respiratory distress (if applicable). 3. Observe for changes in residual volume: a. A sharp increase in residual volume may indicate that a small bowel tube has moved into the stomach; b. Little to no residual volume may suggest that the tube has migrated from the stomach to the esophagus.. 4. If feeding has been interrupted for a few hours, observe (nasogatric, gastric, jejunostomy tubes): a. Fasting stomach contents will have a clear, colorless or green appearance. b. Respiratory secretions may look similar to gastric contents. c. Post-pyloric/intestinal contents cam be bile-stained, light to dark yellow or greenish-brown. 5. If the above suggests improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician..." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures, conduct audits and provide education related to tube feeding procedures to ensure orders are followed and proper procedure is followed in	2 930		

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2 930	Continued From page 14 relation to checking tube feeding placement. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a comprehensive infection control program to include day to day tracking of signs and symptoms of infections not requiring antibiotics, this had the potential to affect all 35 residents. Findings include: The facilities infection control data from September 2018, October 2018 and November 2018 identified the following information: The facilities infection control line by line log for September 2018, October 2018 and November 2018 indicated areas to document resident name, admit date, room number, body system of infection, dates of symptoms, types of symptoms, collection date, type of test, specimen source, results, and antibiotics. However, did not include an area to track illness or symptoms of infection	21375	Corrected	1/8/19

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21375	Continued From page 15 that did not require antibiotic treatment. Although the facility line by line infection control logs identified all the required areas for infections requiring antibiotics, the facility failed to track infections not requiring antibiotics. During interview on 11/29/18, at 10:33 a.m. registered nurse (RN)-A stated the facility does not have a system in place for documenting non antibiotic signs, symptoms or illnesses. RN-A stated all non antibiotic illness and symptoms are all reported verbally during report each morning. RN-A stated non antibiotic illness are not tracked. Rn-A stated she is known as the infection control preventionist in the facility but she was not certified and has not trended or tracked any residents if they are not on an antibiotic. The facility policy, dated 2015, titled Infection Control Program indicated the infection control program exits to assure a safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures, conduct audits and provide education related to the infection control program to ensure tracking of signs and symptoms of illness. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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21390	Continued From page 16	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow proper hand hygiene practice for one of one residents (R29) and failed to disinfect the same residents glucometer when checking a residents blood	21390	Corrected	1/8/19

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21390	Continued From page 17	21390		

sugar. In addition, the facility failed to follow proper hand hygiene for 1 of 3 residents (R14) when provoviding personal care.

Findings include:

R29's Minimal Data Set MDS dated, 10/25/18 indicated R29 was diagnosed with diabetes mellitus and received insulin injections.

On 11/27/18, at 10:59 a.m. licensed practical nurse (LPN)-C was observed to gather the glucometer, a blood glucose strip, lancet and gloves and entered R29's room. LPN-C washed her hands and donned gloves. LPN-C swabbed R29's finger with an alcohol wipe, after it was dry, used the lancet to poke R29's finger, placed the glucose strip in the glucometer and obtained a sample of R29's blood. LPN-C gave R29 a cotton ball for his finger, LPN-C placed the lancet and the used glucose strip into a plastic Dixie cup. LPN-C doffed her gloves, did not wash her hands and grabbed the plastic Dixie cup opened R29's door and proceeded back to the medication cart. LPN-C disposed of the used lancet into the sharps container on the medication cart. LPN-C unlocked the medication cart and placed the glucometer in a basket with R29's insulin pens, locked the medication cart then used hand sanitizer. LPN-C indicated she did not think the glucometer needed to be wiped down after each use since R29 was the only one using it. LPN-C stated she was not aware if there was a policy for cleaning the glucometer. LPN-C did state she should have used hand sanitizer after glove removal.

When interviewed on 11/27/18, at 2:57 p.m. the director of nursing (DON) stated technically the glucometer is designated for that one individual,

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21390	Continued From page 18	21390		

they would only need to clean it if visible with blood. DON stated there is a cleaning policy, but couldn't remember what kind of wipe they are suppose to use. The DON went on to say the nurses and certified nursing assistants have hand sanitizer available to them, hand hygiene needs to be completed after removing gloves.

The Glucometer Cleaning and Disinfecting Policy/Procedure dated 11/16 indicated it is the facilities policy to clean and disinfect the blood glucose meters after each use.

R14's quarterly Minnimum Data Set (MDS), dated 10/9/2018, included diagnosis of dual sensory (hearing and vision) impairment and develpmental disorder of speech and language. The MDS also identified R14's cognition could not be assessed, however, long and short term memory were intact. Also included in the MDS, R14 required extensive assistance with toileting and personal hygiene, was frequently incontinent of urine, and always continent of stool.

During an observation on 11/28/18, at 8:33 a.m. nursing assistant (NA)-C assisted R14 back to her room, from the dining room, via wheelchair. NA-C locked the wheels of the wheelchair and placed a transfer belt around R14's waist. R14 stood up and then pivoted to sit on the toilet with guidance provided by NA-C. NA-C assisted R14 with pullling down pants and brief. R14 made a low throaty sound until the transfer belt was removed. R14 sat on the toilet and stood up when finished. NA-C gloved right hand and used pre-moistened cloth to wipe R14's bottom. NA-C removed the glove, and disposed it into the trash. NA-C assisted R14 with pulling up brief, and placed a transfer belt around R14's waist. R14 made verbal noises and NA-C stepped back,

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	00109	A. BUILDING: _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

(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) COMPLETE DATE
21390	Continued From page 19	21390		

which allowed R14 to wash her hands at the sink. R14 pulled a paper towel to dry hands and reached to drop it in the wastebasket but missed. NA-C picked up the used paper towel with a bare hand and placed it in the trash. Without performing hand hygiene, NA-C assisted R14 to walk to the recliner. R14 pivoted and pulled on the transfer belt until NA-C removed it. R14 adjusted clothing and sat down. NA-C ensured R14 had the call light and, without performing hand hygiene, NA-C walked out of R14's room and headed down the hall toward unit 100 to answer a call light. NA-C walked into the resident's room and touched the resident's shoulder and arm of wheelchair when she spoke. NA-C was stopped and asked to step into the hallway.

When interviewed on 11/28/18, at 8:51a.m. NA-C indicated that hand hygiene should be performed when removing gloves, however, stated that she had not done so after removing her glove after doing peri-care for R14, and verified that R14 had a bowel movement. NA-C immediately left to wash her hands.

The Hand Hygiene Policy undated, indicated hand hygiene must be performed immediately after gloves are removed.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures, conduct audits and provide education to ensure proper procedure is followed in relation to hand hygiene and glucometer disinfection. The DON or designee could develop monitoring systems to ensure ongoing compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: _____ B. WING _____	11/29/2018

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GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

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21390	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and documentation review the facility failed to ensure a residents wheel chair was clean and sanitary for 1 of 1 residents (R30) reviewed for environment. Findings include: R30's admission Minimum Data Sets (MDS) dated 8/30/18, indicated R30 had severely impaired cognition, hypertension (elevated blood pressure), dysphasia (inability to communicate), quadriplegia (paralysis of all 4 limbs), and had a gastrostomy (surgical opening into the stomach) for feedings and medications. R30 required a wheel chair for mobility with staff to propel to all locations. R30's physician's orders dated 10/19/18, indicated R30 was to have nothing by mouth, all feedings and medications by gastrostomy site. During observation on 11/28/18, when observing R30's wheel chair, it was noted to have the appearance of food, dirt and a cream/white substance on the wheels, spokes and frame.	21665	Corrected	1/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21665	Continued From page 21 During observation on 11/29/18, at 9:00 a.m. R30's wheel chair continues to have cream/white substance on the wheels, spokes and frame, along with chunks of food particles in several different places on frame of wheel chair. During interview on 11/29/18, at 10:16 a.m. nursing assistant (NA)-D stated the night shift staff clean the wheel chairs and they have a schedule, although she does not know what their schedule is. NA-D stated they should be cleaning all parts of the wheelchair. NA-D stated R30's wheel chair is not clean and can see food particles, dirt and milk on the tires and both sides of the wheel chair. NA-D stated the wheel chair needs to be cleaned. During interview on 11/29/18, at 10:22 a.m. licensed practical nurse (LPN)-A stated the wheel chairs are supposed to be cleaned weekly on night shift. LPN-A stated the chair is not clean as she could see some kind of food, and white stuff like dried milk all over the wheels and wheelchair spokes. LPN-A stated R30's wheel chair needs to be cleaned. LPN-A removed R30's wheel chair from his room and brought it to an area for house keeping to be cleaned. During interview on 11/29/18 at 10:29 a.m. registered nurse (RN)-A stated R30's wheel chair is not clean as she saw white substance and food particles on wheel, spokes and frame of wheel chair. RN-A stated its horrible and needs to be cleaned. The facilities Weekly Wheelchair Washing Schedule was obtained and R30's wheelchair was scheduled to be cleaned on Monday nights. Documentation verifying R30's wheelchair was cleaned per the schedule was requested but not	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21665	Continued From page 22 received. A facility policy for Medical Equipment Maintenance/Nursing Policy and Procedure dated 10/2017, indicates all equipment used for patient care will function properly and safely by inspecting, maintaining, and cleaning medical equipment on a routine basis. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON), the Director of Maintenance or designee could review and revise policies and procedures, conduct audits and provide education to ensure resident equipment is clean and in good condition. The DON, the Director of Maintenance or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2018

Administrator
Galeon
410 West Main Street
Osakis, MN 56360

Re: State Nursing Home Licensing Orders - Project Number S5465030

Dear Administrator:

The above facility was surveyed on November 26, 2018 through November 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us