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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1HT2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00480

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **137110400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2017**

6. DATE OF SURVEY **10/25/2021** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **107** (L18)

13.Total Certified Beds **107** (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
	107			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jamie Perell, Unit Supervisor 10/28/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/28/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/26/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 28, 2021

CMS Certification Number (CCN): 245340

Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

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 October 14, 2021 the above facility is certified for:

107 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 107 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically Delivered
October 28, 2021

Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

RE: CCN: 245340
Cycle Start Date: October 25, 2021

Dear Administrator:

On October 25, 2021, the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6LRP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00943

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245148**
2.STATE VENDOR OR MEDICAID NO.
(L2) **428658800**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT ST LOUIS PARK LLC**
(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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) **10/01/2017**

6. DATE OF SURVEY **08/19/2021** (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)
12/31

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

12.Total Facility Beds **175** (L18)
13.Total Certified Beds **175** (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
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Renee McClellan, HFE NE II 09/23/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/15/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1968
(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 27, 2021

Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

RE: CCN: 245340
Cycle Start Date: September 2, 2021

Dear Administrator:

On September 2, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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 an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 December 2, 2021 (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 March 2, 2022 (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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	C 09/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/30/21, through 9/2/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/30/21, through 9/2/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED, however, NO deficiencies were cited due to actions implemented by the facility prior to survey: H5340090C (MN00074334) H5340092C (MN00073591) H5340093C (MN00073305) The following complaints were found to be UNSUBSTANTIATED: H5340087C (MN00076031) H5340088C (MN00074663) H5340089C (MN00074590) H5340091C (MN00073663) H5340094C (MN00076218 & MN00076207)	F 000		

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

Electronically Signed | 10/07/2021

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
	245340	A. BUILDING _____ B. WING _____	C 09/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed implement interventions to monitor and maintain a wound drain for 1 of 1 resident (R132) who had an infection. Findings include: R132's admission Minimum Data Set (MDS) dated 8/27/21, indicated R132 had intact cognition and diagnoses which included heart failure and septicemia (infection). R132 had not rejected care and required extensive assistance	F 684	F- 684 Resident R132, no longer resides at the Galtier a Villa Center Residents with wound drains have the potential to be affected by this practice. Residents with wound drains have received assessments, order reviews, and care plan updates to ensure appropriate cares are being delivered. Residents with wound drains have the potential to be affected by this practice. Resident□s that currently have a wound	10/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	C 09/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2 with dressing and personal hygiene. R132's hospital discharge summary dated 8/21/21, indicated R132 had abscesses (confined pocket of puss when an area of the body becomes infected) of multiple sites. R132 was to have drain care which included flushing a drainage tube with 10 milliliters (mL) of sterile normal saline daily. R132's drain output was to be recorded. Additionally, the facility was to notify radiology with any drainage tube related questions or concerns such as if output suddenly stopped or significantly reduces or if there was any leakage, warmth, redness, swelling or tenderness around the drainage tube. The discharge summary lacked direction for drain dressing changes. R132's Order Summary Report dated 8/21/21, lacked indication of drain care, flushes, or dressing changes. R132's Care Plan dated 8/30/21, lacked indication of drain care, flushes, or dressing changes. Review of R132's progress notes dated 8/21/21, through 8/31/21, lacked documentation of drain site care on seven of 11 days. During an interview on 8/30/21, at 2:08 p.m. R132 stated she had a drain near the back of her hip and, "they flushed it [drain] twice a day at the hospital. I am lucky if I get it flushed once a day here." R132 stated nurses had not changed her drain dressing since being admitted from the hospital. During an interview on 8/30/21, at 5:37 p.m.	F 684	drain have been re-assessed and care plans have been updated as appropriate. Orders have been reviewed to ensure they meet standards of practice and follow physician orders. License nurses and clinical leadership have been educated on policies and procedures for wound care and care of drains orders. Policies and procedures have been reviewed and are current. Nursing management team will be re-educated on the development of initial care plan including ongoing monitoring of drains, flush and dressing changes including skin integrity issues. DON/Designee will conduct audits 3x/week x 3 weeks, then 2x monthly x 2 months wound drains. DON/Designee will forward results of all audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Compliance date: 10/14/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	C 09/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3	F 684		

licensed practical nurse (LPN)-A stated she worked with R132 since her admission but had not completed a dressing change for R132 as there were no orders.

During an observation on 8/30/21, at 6:39 p.m. LPN-B stated he was preparing to administer an antibiotic to R132. LPN-B entered the room and R132 asked if LPN-B was going to flush her drain. R132 stated, "Usually they do that when they start my antibiotic." LPN-B exited the room and stated he did not see orders for drain care. LPN-B stated he would know how to proceed.

During interview on 8/30/21, at 7:05 p.m. the director of nursing (DON) verified R132's orders lacked direction for drain care. The DON agreed if a resident lacked orders for nursing treatment nurses were expected to call the provider for order clarification.

During an interview on 8/30/21, at 7:23 p.m. nurse practitioner (NP)-A stated she would have expected nurses to follow R132's discharge orders. If the discharge orders lacked detail, NP-A expected a call from the nurses to clarify care. NP-A stated if proper care was not being provided, drain tubes could get clogged. NP-A stated she would expect R132's drain dressing to be changed at least daily. NP-A reviewed R132's medical record and agreed it lacked direction for drain care, flushes, output monitoring, or dressing changes.

During an observation on 8/30/21, at 7:29 p.m. the DON entered R132's room and asked to see the drain site. An undated gauze bandage was observed over the drain site. The gauze was discolored gray, and the layers of the gauze

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	C 09/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4 dressing had started to peel apart. The DON verified R132's dressing looked old and needed to be changed. During an interview on 9/1/21, at 11:10 a.m. LPN-C stated he worked with R132 since admission. LPN-C stated there were no orders for drain care. LPN-C stated he had not changed the drain dressing due to the lack of orders. Facility policy for drain care was requested but not provided.	F 684		
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 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	F 693		10/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	C 09/02/2021

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GALTIER A VILLA CENTER	**445 GALTIER AVENUE SAINT PAUL, MN 55103**

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F 693	Continued From page 5 by: Based on observation, interview, and document review, the facility failed to ensure care of a feeding tube was provided in a manner to prevent the spread of infection for 1 of 1 resident (R12) reviewed for tube feedings. Findings include: R12's Face Sheet dated 9/1/21, identified diagnoses of stroke and hemiplegia (paralysis on one side of the body). R12's quarterly Minimum Data Set (MDS) dated 7/10/21, indicated R12 had severely impaired cognition and required extensive assistance personal hygiene and bed mobility. R12 had a feeding tube. R12's care plan dated 12/14/20, indicated R12 had a feeding tube related to inadequate intake. R12 was to remain free of signs and symptoms of infection through the review date. Interventions included monitoring the gastric tube (G-tube) site, as ordered, and monitor for signs and symptoms of infection. During an observation on 8/31/21 at 9:51 a.m. registered nurse (RN)-B entered R12's room with morning medications. RN-B turned R12's feeding pump off and removed R12's blankets. RN-B disconnected the tube feeding and hung the tubing over a pole. RN-B removed the plunger from a 60 cubic centimeter (cc) syringe and placed the plunger on a bedside table. RN-B inserted the syringe into the feeding tube port and poured water into the syringe, however, the water did not flow via gravity. RN-B then grabbed a garbage can and placed it on R12's bed. RN-B	F 693	F-693 R12 is receiving tube feeding care in a manner to prevent the spread of infection that is consistent with standards of care. Care plan has been updated to reflect changes as appropriate. Residents that reside at Galtier a Villa Center that have a tube feeding have the potential to be affected by this practice. Residents with feeding tubes will be reviewed to ensure cares plans, orders and care of feeding tube is being provided per standard of practice. License nurses and clinical leadership have been educated on policies and procedures for tube feeding per standards of practice. Policies and procedures have been reviewed and are current. DON/Designee will audit patients on tube feeding weekly to ensure tube feeding is being provided in a manner that supports standards of practice. Audits will be conducted 3 times weekly x 2 weeks, then monthly x 3 months. All Audits will be brought through QAPI and reviewed for continued quality improvement Completion Date: 10/14/21	

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F 693	Continued From page 6 tipped the fluid filled syringe into the garbage can while still connected to R12's feeding tube. The syringe connected to R12's feeding tube came into direct contact with the garbage can. RN-B then removed the syringe from R12's feeding tube and placed the contaminated syringe in a fluid filled graduate container and started to fill the syringe. The surveyor intervened at this time and alerted RN-B the supplies were contaminated. RN-B confirmed the equipment was contaminated and obtained new equipment to flush the feeding tube prior to administering medication. Facility policy titled Tube Feeding dated 6/29/21, lacked indication of flushing a feeding tube.	F 693		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		10/14/21

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F 812	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to distribute food with a safe and sanitary manner to prevent the potential of food borne illness. This had the potential to affect all residents who were served room trays from the facility dining room. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/11/21, indicated R13 ate independently and used a wheelchair. R13's diagnoses included seizure disorder. During an observation on 8/30/21, at 12:40 p.m. nine residents were noted to be seated at tables and were served lunch in the facility dining room. R13 was noted to touch a piece of chicken with his fingers which was on his plate. At 12:50 p.m., R13 wheeled to the steam table and asked for something else to eat. Dietary aide (DA)-A walked to R13's place setting, picked up R13's plate, and walked back to the steam table. DA-A picked up serving tongs and removed the chicken off of R13's plate. DA-A then put the piece of chicken into a container which held chicken waiting to be served on the steam table. Eight residents were awaiting room trays to be served. The surveyor intervened and DA-A was notified the chicken container was now contaminated and the container of chicken was removed at this time. During an interview on 8/30/21, at 12:55 p.m. DA-A verified he put R13's chicken back in the serving container. DA-A stated he should not had placed the chicken back in the serving container as it was an infection control issue.	F 812	F-812 R13 was not affected by this deficient practice. All residents have the potential to be affected by this practice. Nursing and dietary staff will be educated on safe and sanitary food handling. Education to be provided by DON or designee. Audits will be completed 4x weekly during different mealtimes to ensure compliance of safe and sanitary food handling. Audits will be completed by Administrator or designee. Results of the audits will be brought to QAPI by Administrator or designee to review trends. Compliance date: 10/14/2021	

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	245340	A. BUILDING _____ B. WING _____	C 09/02/2021

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F 812	Continued From page 8 During an interview on 9/1/21, at 1:57 p.m. the nutrition services director verified staff should never take food that had been served and bring it back to the steam table and put food back in the serving container. If this did happen, all food would have to be thrown out as it would be contaminated. The facility Infection Prevention and Control Program revised 1/1/21, indicated the purpose is to 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	F 812		

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	245340	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**08/31/2021**

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GALTIER A VILLA CENTER	**445 GALTIER AVENUE** **SAINT PAUL, MN 55103**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/31/2021. At the time of this survey, Galtier a Villa Center was found 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Galtier a Villa Center is a 4-story building with a basement that was built in 1963 and was determined to be of Type II(222) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 107 beds and had a census of 79 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

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

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

Electronically delivered
September 27, 2021

Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

Re: State Nursing Home Licensing Orders
Event ID: 1HT211

Dear Administrator:

The above facility was surveyed on August 30, 2021 through September 2, 2021 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00480	A. BUILDING: _____ B. WING _____	C 09/02/2021

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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: On 8/30/21, through 9/2/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1	2 000		

these orders, and identify the date when they will be completed.

The following complaintswere found to be SUBSTANTIATED, however, no citations were issued.
H5340090C (MN00074334)
H5340092C (MN00073591)
H5340093C (MN00073305)

The following complaints were found to be UNSUBSTANTIATED:
H5340087C (MN00076031)
H5340088C (MN00074663)
H5340089C (MN00074590)
H5340091C (MN00073663)
H5340094C (MN00076218 & MN00076207)

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.

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

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2 000	Continued From page 2 delineated on the attached Minnesota 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. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced	2 830		10/7/21

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2 830	Continued From page 3 by: Based on observation, interview, and document review, the facility failed implement interventions to monitor and maintain a wound drain for 1 of 1 resident (R132) who had an infection. Findings include: R132's admission Minimum Data Set (MDS) dated 8/27/21, indicated R132 had intact cognition and diagnoses which included heart failure and septicemia (infection). R132 had not rejected care and required extensive assistance with dressing and personal hygiene. R132's hospital discharge summary dated 8/21/21, indicated R132 had abscesses (confined pocket of puss when an area of the body becomes infected) of multiple sites. R132 was to have drain care which included flushing a drainage tube with 10 milliliters (mL) of sterile normal saline daily. R132's drain output was to be recorded. Additionally, the facility was to notify radiology with any drainage tube related questions or concerns such as if output suddenly stopped or significantly reduces or if there was any leakage, warmth, redness, swelling or tenderness around the drainage tube. The discharge summary lacked direction for drain dressing changes. R132's Order Summary Report dated 8/21/21, lacked indication of drain care, flushes, or dressing changes. R132's Care Plan dated 8/30/21, lacked indication of drain care, flushes, or dressing changes. Review of R132's progress notes dated 8/21/21,	2 830	CORRRECTED	

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2 830	Continued From page 4 through 8/31/21, lacked documentation of drain site care on seven of 11 days. During an interview on 8/30/21, at 2:08 p.m. R132 stated she had a drain near the back of her hip and, "they flushed it [drain] twice a day at the hospital. I am lucky if I get it flushed once a day here." R132 stated nurses had not changed her drain dressing since being admitted from the hospital. During an interview on 8/30/21, at 5:37 p.m. licensed practical nurse (LPN)-A stated she worked with R132 since her admission but had not completed a dressing change for R132 as there were no orders. During an observation on 8/30/21, at 6:39 p.m. LPN-B stated he was preparing to administer an antibiotic to R132. LPN-B entered the room and R132 asked if LPN-B was going to flush her drain. R132 stated, "Usually they do that when they start my antibiotic." LPN-B exited the room and stated he did not see orders for drain care. LPN-B stated he would know how to proceed. During interview on 8/30/21, at 7:05 p.m. the director of nursing (DON) verified R132's orders lacked direction for drain care. The DON agreed if a resident lacked orders for nursing treatment nurses were expected to call the provider for order clarification. During an interview on 8/30/21, at 7:23 p.m. nurse practitioner (NP)-A stated she would have expected nurses to follow R132's discharge orders. If the discharge orders lacked detail, NP-A expected a call from the nurses to clarify care. NP-A stated if proper care was not being provided, drain tubes could get clogged. NP-A	2 830		

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2 830	Continued From page 5 stated she would expect R132's drain dressing to be changed at least daily. NP-A reviewed R132's medical record and agreed it lacked direction for drain care, flushes, output monitoring, or dressing changes. During an observation on 8/30/21, at 7:29 p.m. the DON entered R132's room and asked to see the drain site. An undated gauze bandage was observed over the drain site. The gauze was discolored gray, and the layers of the gauze dressing had started to peel apart. The DON verified R132's dressing looked old and needed to be changed. During an interview on 9/1/21, at 11:10 a.m. LPN-C stated he worked with R132 since admission. LPN-C stated there were no orders for drain care. LPN-C stated he had not changed the drain dressing due to the lack of orders. Facility policy for drain care was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee, could review and revise policies and procedures related to the provision of care to drains. Facility staff could be educated on these policies and procedures. The administrator, DON, or designee, could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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	00480	A. BUILDING: _____ B. WING _____	C 09/02/2021

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2 930	Continued From page 6	2 930		
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 ensure care of a feeding tube was provided in a manner to prevent the spread of infection for 1 of 1 resident (R12) reviewed for tube feedings. Findings include: R12's Face Sheet dated 9/1/21, identified diagnoses of stroke and hemiplegia (paralysis on one side of the body). R12's quarterly Minimum Data Set (MDS) dated 7/10/21, indicated R12 had severely impaired cognition and required extensive assistance personal hygiene and bed mobility. R12 had a feeding tube. R12's care plan dated 12/14/20, indicated R12	2 930	CORRECTED	10/7/21

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2 930	Continued From page 7 had a feeding tube related to inadequate intake. R12 was to remain free of signs and symptoms of infection through the review date. Interventions included monitoring the gastric tube (G-tube) site, as ordered, and monitor for signs and symptoms of infection. During an observation on 8/31/21 at 9:51 a.m. registered nurse (RN)-B entered R12's room with morning medications. RN-B turned R12's feeding pump off and removed R12's blankets. RN-B disconnected the tube feeding and hung the tubing over a pole. RN-B removed the plunger from a 60 cubic centimeter (cc) syringe and placed the plunger on a bedside table. RN-B inserted the syringe into the feeding tube port and poured water into the syringe, however, the water did not flow via gravity. RN-B then grabbed a garbage can and placed it on R12's bed. RN-B tipped the fluid filled syringe into the garbage can while still connected to R12's feeding tube. The syringe connected to R12's feeding tube came into direct contact with the garbage can. RN-B then removed the syringe from R12's feeding tube and placed the contaminated syringe in a fluid filled graduate container and started to fill the syringe. The surveyor intervened at this time and alerted RN-B the supplies were contaminated. RN-B confirmed the equipment was contaminated and obtained new equipment to flush the feeding tube prior to administering medication. Facility policy titled Tube Feeding dated 6/29/21, lacked indication of flushing a feeding tube. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure resident with feeding tubes	2 930		

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2 930	Continued From page 8 are cared for in a sanitary manner. The DON, or designee, could educate all appropriate staff on the policies and procedures. The DON, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to distribute food with a safe and sanitary manner to prevent the potential of food borne illness. This had the potential to affect all residents who were served room trays from the facility dining room. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/11/21, indicated R13 ate independently and used a wheelchair. R13's diagnoses included seizure disorder. During an observation on 8/30/21, at 12:40 p.m. nine residents were noted to be seated at tables and were served lunch in the facility dining room. R13 was noted to touch a piece of chicken with his fingers which was on his plate. At 12:50 p.m.,	21015	CORRECTED.	10/7/21

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21015	Continued From page 9 R13 wheeled to the steam table and asked for something else to eat. Dietary aide (DA)-A walked to R13's place setting, picked up R13's plate, and walked back to the steam table. DA-A picked up serving tongs and removed the chicken off of R13's plate. DA-A then put the piece of chicken into a container which held chicken waiting to be served on the steam table. Eight residents were awaiting room trays to be served. The surveyor intervened and DA-A was notified the chicken container was now contaminated and the container of chicken was removed at this time. During an interview on 8/30/21, at 12:55 p.m. DA-A verified he put R13's chicken back in the serving container. DA-A stated he should not had placed the chicken back in the serving container as it was an infection control issue. During an interview on 9/1/21, at 1:57 p.m. the nutrition services director verified staff should never take food that had been served and bring it back to the steam table and put food back in the serving container. If this did happen, all food would have to be thrown out as it would be contaminated. The facility Infection Prevention and Control Program revised 1/1/21, indicated the purpose is to 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 SUGGESTED METHOD FOR CORRECTION: The administrator and dietician could review review and/or revise food service policies and procedures to assure that food is served in a sanitary manner.	21015		

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21015	Continued From page 10 The administrator and dietician could provide education on safe food handling practices. The administrator and dietician could conduct audts of meal service to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		