DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICAT							
	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY	AGENCY		Facility ID: 00480
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245340).	3. NAME AND ADI (L3) GALTIER H					4. TYPE OF ACTION	: <u>7 (</u> L8)
(L1) 245340 2.STATE VENDOR OR MEDICAID NO.		(L4) 445 GALTIE					1. Initial	2. Recertification
(L2) 137110400		(L5) SAINT PAUL			(1	L6) 55103	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN	ERSHIP	7. PROVIDER/SUF	PPLIER CATEGOR	Y	02	(L7)	7. On-Site Visit	9. Other
(L9) 07/01/2015		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey After C	Complaint
6. DATE OF SURVEY 09/19 /	2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR ENDING	G DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPIC	Е	09/30	
		10.THE FACILITY						
11LTC PERIOD OF CERTIFICATION From (a) :		X A. In Compliar			And/Or An	proved Waivers Of The	Following Requirements:	
To (b):		Program Red			-	Technical Personnel	6. Scope of Ser	
		Compliance				24 Hour RN	7. Medical Dire	
12 T-4-1 E	107 (119)	1. A	cceptable POC		4.	7-Day RN (Rural SNF)	8. Patient Room	Size
12.Total Facility Beds 13.Total Certified Beds	107 (L18)107 (L17)	D. Not in Com	pliance with Progran		5. 1	Life Safety Code	9. Beds/Room	
13. Iotal Cettilied Beds	107 (L17)		and/or Applied Waiv		* Code:	A*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILIT			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
107								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):		<u> </u>			
17. SURVEYOR SIGNATURE		Date :			18. STATE S	SURVEY AGENCY AP	PROVAL	Date:
Susanne Reuss, U	nit Supervis	sor	09/19/2016	(L19)	Kate J	ohnsTon, Pr	ogram Speciali	<u>St</u> 10/25/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE O	R SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH C	IVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
X 1. Facility is Eligible to Part	cipate	RIGH	ITS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	ENT	26. TERMI	NATION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	E	VOLUNTAR	<u> </u>	INVOLUN	TARY
09/01/1986					01-Merger, C	losure	05-Fail to M	Neet Health/Safety
(L24)	(L41)		(L25)			ction W/ Reimbursemer	nt 06-Fail to M	Aeet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS				voluntary Termination	OTHER	
	A. Suspension	of Admissions:			04-Other Rea	son for Withdrawal		r Status Change
(L27)	B. Rescind Sus	nension Date:	(L44)				00-Active	
	D. Resente Sus	pension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMAR	KS		
20. TERMINATION DITE:	_/		induzit ito:		50. HERRI HE			
	06301 (L28) (
					Postad 1	.0/31/2016 Co.		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (OF APPROVAL DA	ΓE	rosted 1	U/J1/2010 CO.		
	(L32)	09/07/2016		(L33)	DETERM	INATION APPRO	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245340 October 25, 2016

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

Dear Mr. Thompson:

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 September 13, 2016 the above facility is certified for or recommended 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Galtier Health Center October 25, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered October 25, 2016

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

RE: Project Number S5340025

Dear Mr. Thompson:

On August 18, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 4, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 21, 2016 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 August 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 4, 2016, effective September 13, 2016 and therefore remedies outlined in our letter to you dated August 18, 2016, 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.

Galtier Health Center October 25, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	 MULTIPLE CONSTRUCTION A. Building		Γ	DATE OF REVISIT	
245340	 B. Wing	Y2	9	9/19/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GALTIER HEALTH CENTER		445 GALTIER AVENUE			
		SAINT PAUL, MN 55103			

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

ITEI	М	DATE	ITEM		DATE	ITEM		[DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0241	Correction	ID Prefix F02	258	Correction	ID Prefix	F0279	C	orrection
Reg. #	483.15(a)	Completed	483. Reg. #	.15(h)(7)	Completed	Reg. #	483.20(d), 483.20(k))(1) C	ompleted
LSC		09/13/2016			09/13/2016	LSC		09	9/13/2016
ID Prefix	F0314	Correction	ID Prefix F03	315	Correction	ID Prefix	F0406	С	orrection
Reg. #	483.25(c)	Completed	Reg. #	.25(d)	Completed	Reg. #	483.45(a)	C	ompleted
LSC		09/13/2016	LSC		09/13/2016	LSC		09	9/13/2016
ID Prefix	F0431	Correction	ID Prefix F04	141	Correction	ID Prefix	F0465	C	orrection
Reg. #	483.60(b), (d), (e)) Completed	483. Reg. #	.65	Completed	Reg. #	483.70(h)	C	ompleted
LSC		09/13/2016			09/13/2016	LSC		09	9/13/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		C	orrection
Reg. #		Completed	Reg. #		Completed	Reg. #		C	ompleted
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		C	orrection
Reg. #		Completed	Reg. #		Completed	Reg. #		C	ompleted
LSC						LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) SR/KJ	date 10/25/201	SIGNATURE OF SU		16022		date 09/19/2	2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWI 8/4/2016	JP TO SURVEY CO	OMPLETED ON		FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF RECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			YES	NO	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING			
245340 _{Y1}	B. Wing	Y2	9/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIER HEALTH CENTER		445 GALTIER AVENUE		
		SAINT PAUL, MN 55103		

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

ITE	M	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix Reg. # LSC	NFPA 101 K0038	Correction Completed 09/13/2016	ID Prefix Reg. # LSC K0066	01 Correction 02 Completed 09/13/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
REVIEWE STATE AG REVIEWE CMS RO FOLLOWI 8/3/2016		REVIEWED BY (INITIALS) TL/KJ REVIEWED BY (INITIALS)		SIGNATURE OF SURVEYOR 19 TITLE ANY UNCORRECTED DEFICIENCIES ED DEFICIENCIES (CMS-2567) SEN		DATE 09/21/2016 DATE

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF REVIS	ыт
245340	B. Wing	Y2	9/19/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIER HEALTH CENTER		445 GALTIER AVENUE		
		SAINT PAUL, MN 55103		

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

ITEN	Λ	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
	F0314 483.25(c)	Correction Completed	ID Prefix F0315 Reg. #	d) Correction	ID Prefix - Reg. #	Correction
LSC		09/13/2016	LSC	09/13/2016	LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # LSC		Completed	Reg. #	Completed	Reg. # 	Completed
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
REVIEWED STATE AG		REVIEWED BY (INITIALS) SR/KJ	date 10/25/2016	SIGNATURE OF SURVEYOR	16022	date 09/19/2016
REVIEWED CMS RO	р вү	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/4/2016			ANY UNCORRECTED DEFICIENCIES ED DEFICIENCIES (CMS-2567) SEN			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA ` I - TO BE COM						ID: CSZD
 MEDICARE/MEDICAID PROVIDER NO (L1) 245340 STATE VENDOR OR MEDICAID NO. (L2) 122110400 		3. NAME AND ADI (L3) GALTIER H (L4) 445 GALTIE	DRESS OF FACILIT EALTH CENTER R AVENUE	Y			 TYPE OF ACTION Initial Termination 	 Recertification CHOW
(L2) 137110400 5. EFFECTIVE DATE CHANGE OF OWN (L9) 07/01/2015	VERSHIP	(L5) SAINT PAUI 7. PROVIDER/SUF 01 Hospital	2, MN PPLIER CATEGORY 05 HHA	09 ESRD		L6) 55103 (L7) 22 CLIA	5. Validation 7. On-Site Visit 8. Full Survey After (6. Complaint 9. Other Complaint
6. DATE OF SURVEY 08/04/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	Е	FISCAL YEAR ENDIN 09/30	G DATE: (L35)
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 	107 (L18) 107 (L17)		nce With quirements		2. 7 3. 2 4. 7	proved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code	Following Requirements: 6. Scope of Se 7. Medical Dir 8. Patient Room 9. Beds/Room	rvices Limit ector
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	Requirements a	and/or Applied Waive IID	ers:	* Code: 15. FACILIT 1861 (e) (1)	B* TY MEETS) or 1861 (j) (1):	(L12) (L15)	
107 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):		I			
17. SURVEYOR SIGNATURE		Date :			18. STATE S	SURVEY AGENCY AP	PROVAL	Date:
Robyn Woolley	, HFE NE I	[08/30/2016	(L19)	Kate J	ohnsTon, Pr	ogram Special	09/01/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE O	R SINGLE STAT	EAGENCY	
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 	icipate		IPLIANCE WITH CI ITS ACT:	VIL	 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 09/01/1986 (L24)	23. LTC AGREEMI BEGINNING 1 (L41)		 LTC AGREEME! ENDING DATE (L25) 		<u>VOLUNTAR</u> 01-Merger, C		INVOLUN 05-Fail to	(L30) <u>\TARY</u> Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of	of Admissions:	(L44)			voluntary Termination son for Withdrawal	OTHER 07-Provide 00-Active	er Status Change
(=)	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARI	KS		
	(L28)	06301		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	E	Posted	09/06/2016 Co.		
	(L32)			(L33)	DETERM	INATION APPRO	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 17, 2016

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

RE: Project Number S5340025

Dear Mr. Thompson:

On August 4, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at Galtier Health Center August 17, 2016 Page 2

the time of a revisit;

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

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793 Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 13, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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

Galtier Health Center August 17, 2016 Page 4

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 4, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 4, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

> Nursing Home Informal Dispute Process Minnesota Department of Health 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

Galtier Health Center August 17, 2016 Page 6

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

Feel free to contact me if you have questions.

Sincerely,

Tomston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245340	B. WING		C 08/04/2016
	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 45 GALTIER AVENUE AINT PAUL, MN 55103	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
		ey was conducted August 1, nplaint investigations were time of the standard			
	#H5340041 were com	mplaints #H5340040 and npleted. The complaints nd deficiencies were cited at			
	as your allegation of o Department's accepta enrolled in ePOC, you at the bottom of the fi	ance. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will			
F 241 SS=D	on-site revisit of your validate that substant regulations has been your verification. 483.15(a) DIGNITY A	ceptable electronic POC, an facility may be conducted to ial compliance with the attained in accordance with ND RESPECT OF	F 241		9/13/16
	manner and in an env	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.			
	by: Based on observation review, the facility fail	is not met as evidenced n, interview, and document ed to provide services in a ted dignity for two of two		"This Plan of Correction constitutes thi facility's written allegation of complianc for the deficiencies cited. This	
		SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE
Electroni	cally Signed				08/26/2016

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 09/01/2016

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 245340 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 445 GALTIER AVENUE GALTIER HEALTH CENTER SAINT PAUL, MN 55103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 241 Continued From page 1 F 241 residents (R89, R9) who reported they were not submission of this plan of correction is not treated in a dignified manner. an admission of or agreement with the deficiencies or conclusions contained in Findings include: the Department's inspection report." R89 was assessed as moderate cognition related R9 and R89 have been assessed related to dementia according to the 6/27/16 care area to the treatment with respect and dignity assessment (CAA) and required staff assistance and no further findings. with activities of daily living with redirection and reapproach. Staff identified will have 1:1 education completed on 8/3/16. During an interview on 8/1/16, at 5:58 p.m. R89 expressed staff did not treat her with respect and Residents @ Galtier Health Center will be dignity. R89 further stated that about one week treated with dignity and respect. prior, a staff member on the evening shift had answered her call light by stating abruptly, "What The staff were provided education on do you want?" The resident said she had reported Dignity and Respect on 8/3/16. the incident to a night staff. R89 stated the way the staff had spoken to her made her feel The staff are being re-educated on "unimportant." treating the residents with dignity and respect. During observations of cares on 8/3/16, at 10:45 a.m. licensed practical nurse (LPN)-A failed to Caring Partners will interview residents inform R89 of the process required to complete a regarding treatment of resident's with dressing change, failed to talk with R89 during dignity and respect weekly x 8 weeks, if additional treatments being completed and failed audits are satisfactory, will decrease to explain the steps of the treatment. R89 was audits to monthly x 3 months, if upset and LPN-A failed to acknowledge that R89 satisfactory will complete audits quarterly. was crying throughout the cares provided. Results of the audits will be reported R9 was assessed as cognitively intact according monthly at the QAPI meeting. to the minimum data set (MDS) admission 5/26/16, and required total assistance with The Director of Social Service will be activities of daily living. responsible to monitor compliance. During an observation on 8/3/16, at 9:05 a.m. LPN-A handed R9 medications stating, "Here are your meds." R9 responded by stating, "These are just vitamins. I don't need them" and threw the

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 09/01/2016 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		245340	B. WING			08/0	C 04/2016
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
GALTIER	HEALTH CENTER			45 GALTIER AVENUE SAINT PAUL, MN 5510	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	you do that for?" LPN pick up the trash bag was no explanation of what they were for or medications. LPN-A to when R9 asked LPN- my dressing?" LPN-A and walk down the ha R9. R9 called out loud change my dressing? return to R9's room, to hallway that she woul obtained the supplies R9 stated, "That mad unimportant." During an observation LPN-A returned to R9 dressing change. Dur informed LPN-A, "Thi did not respond and of dressing change. R9 stated to the resident, resident held LPN-A's wound care. Review of R9's record Progress Notes, date pain assessment. Res in pain medsReside and explain cares ste anxiety and/or pain do When interviewed on registered nurse (RN) expectations were for	 sh. LPN-A stated, "What did I-A was then observed to and leave the room. There f what the medications were, the importance of the urned to leave the room A, "Are you going to change a continued to exit the room all without acknowledging der, "Are you going to " LPN-A did not stop and but called back from the Id come back after she . Following the interaction e me feel ignored and n on 8/3/16, at 9:15 a.m. P's room to perform a ring the dressing change, R9 s hurts you know." LPN-A continued to perform the then stated, "Ouch!" LPN-A, ,"I haven't touched it." The s arm from performing d, a document titled, d, 8/3/16, read, "Completed sident recently had increase ent to participate in cares p by step to decrease uring cares." 8/4/16, at 9:50 a.m. B reported the staff to follow the facility's policy. Staff were to introduce 	F 241				

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 09/01/2016 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	I	(X3) DATE COMP	SURVEY LETED
		245340	B. WING				C 04/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
GALTIER	HEALTH CENTER			445 GALTIER AVENUE SAINT PAUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 241 F 258 SS=E	medications and treat resident. RN-B verified during cares and treat the resident what you of the procedure. Document review of th Resident Rights, inclu Rights which read, "D and Participation. You care from the facility in environment that prom enhances dignity and your individuality." 483.15(h)(7) MAINTE COMFORTABLE SOU	ments, and to engage the d the facility expectation tments would be to inform are doing during each step he dated 7/15 policy titled, ided the Resident Bill of ignity/Self Determination i have the right to receive in a manner and in an notes, maintains, or respect if full recognition of NANCE OF JND LEVELS ide for the maintenance of	F 24				9/13/16
	by: Based on observation review, the facility faile and comfortable envir residents (R29, R89, I environmental concer Findings include: On 8/3/16, at 1:00 p.n tour with the maintena manager housekeepir district manager (DM) were discussed. R29 had stated it was when going to bed. R2	R107, R66) reviewed for ns. n. during the environmental ance supervisor (MS), ng (MH), manager (M), and n, the following concerns		Resident's R29, R89 offered ear plugs. Ca assistant assignment updated accordingly. 8/26/16. Galtier Health Center a functional and comf The staff on duty wer level concerns on 8/3 The staff are being re comfortable sound let	are plans and nursi sheets will be Completion date 's goal is to mainta fortable environme e educated on nois /16.	ing ain ent. se	

Facility ID: 00480

If continuation sheet Page 4 of 25

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 245340 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 445 GALTIER AVENUE GALTIER HEALTH CENTER SAINT PAUL, MN 55103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 258 Continued From page 4 F 258 and staff yelled in the hallway. MS stated would be available to the residents at the nurses need to address concern with unit nurse manager station. Completion date 8/25/16. and interim director of nursing (IDON). Caring Partners will interview residents R89 had stated the nurses yelled in the hallway, about sound levels weekly x 8 weeks, if did not speak normally, just screamed and was audits are satisfactory will decrease audits unable to sleep due to their yelling. M stated to monthly x 3 months, if satisfactory will would relay to the IDON that sounds echo. complete audits quarterly. R107 had stated staff should be quiet at night. Results of audits will be reported monthly Staff and residents were too noisy, talking and at the QAPI meeting. hollering. M stated the noise could echo because there was no carpeting. The Executive Director will be responsible to monitor compliance. R66 had stated residents were up all night long, walking up and down the halls, and nurses did not tell residents to go to sleep. M stated staff could not make residents go to bed and medications could possibly keep residents awake. On 8/4/16, noise level complaint information was provided to the interim director of nursing (IDON) who confirmed it was unacceptable. Facility did not provide a noise level policy. F 279 F 279 483.20(d), 483.20(k)(1) DEVELOP 9/13/16 COMPREHENSIVE CARE PLANS SS=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00480

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PRINTED: 09/01/2016

	IDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938-0391
	IFICATION NUMBER:		3	(X3) DATE SURVEY COMPLETED C
	245340	B. WING		08/04/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GALTIER HEALTH CENTER			445 GALTIER AVENUE SAINT PAUL, MN 55103	
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE I TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 279 Continued From page 5		F 27	79	
 The care plan must describe the to be furnished to attain or main highest practicable physical, man psychosocial well-being as requived under §483.25; and any services that be required under §483.25 but due to the resident's exercise of §483.10, including the right to funder §483.10(b)(4). This REQUIREMENT is not may by: Based on document review are facility did not develop a complexate including required active the resident (R99) reviewed for president (R99). During interview on 8/4/16, at 9 worker (SS)-A was asked for dimensional set of the review of the	ntain the resident's iental, and uired under would otherwise are not provided of rights under refuse treatment et as evidenced ad interview, the rehensive plan of reatment for 1 of 1 eadmission ed that R99 was noses including . An Evaluative Greening form, etardation" as a e Need For Active read, "This person The local agency at needs have been dual service plan on resides in the lan of care, dated treatment		 R99's Level II Preadmission Screeni has been redone. Completed 8/24/1 R99's care plan has been updated w interventions to address any special needs related to qualifying Level II diagnosis. Completed 8/24/16. Resident's medical reocrds were aud for Preadmission screening and their for active treatment. Completed 8/19 Care plans have been updated as needed. Social worker will audit new residents an ongoing basis for indications that active treatment is required during Comprehensive Care Plan Review. Audit results will be reported in the Q monthly meeting x 3 months or until deemed necessary to monitor compliance. The Director of Social Services will be 	5. th ited jeed /16. s on

Facility ID: 00480

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		245340	B. WING		C	
	ROVIDER OR SUPPLIER	245540		STREET ADDRESS, CITY, STATE, ZIP CODE	08/04/2016	
	NONDER OR OUT LIER			45 GALTIER AVENUE		
GALTIER	HEALTH CENTER			SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE	
F 279	Continued From page	e 6	F 279			
	could not locate docu treatment for R99. T facility's procedure for for residents with a L Screening that detern needed. SS-A stated not have a procedure treatment, and this w needed to develop go	he surveyor asked for the r providing active treatment evel II Preadmission nined active treatment was I that the facility currently did to provide the active as something the facility bing forward.		responsible to monitor compliance.		
F 314 SS=D	483.25(c) TREATME PREVENT/HEAL PR		F 314		9/13/16	
	resident, the facility n who enters the facility does not develop pre individual's clinical co they were unavoidab pressure sores receiv	chensive assessment of a nust ensure that a resident y without pressure sores ssure sores unless the ondition demonstrates that le; and a resident having yes necessary treatment and healing, prevent infection and om developing.				
	by: Based on observation review, the facility fait repositioning for 1 of	 is not met as evidenced in, interview, and document led to provide timely 2 residents (R9) who was ressure ulcer development. 		Resident R9's skin risk and need for repositioning will be reevaluated and ca plan updated as needed. NA responsible for R9 on 8/3/16 receiv		
	Findings include:			a disciplinary action on 8/16/16.		
	to the minimum data	I total assistance with		Nursing assistant assignment sheets, care plans and tissue tolerance sheets Indicated) have been audited for reside who require assistance with positioning appropriate frequency of repositioning.	ents for	

Event ID: CSZD11

Facility ID: 00480

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		X3) DATE S	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	l` í		()	COMPLI	
						С	
		245340	B. WING			08/04/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GALTIER	HEALTH CENTER			445 GALTIER AVENUE			
				SAINT PAUL, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE "ERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETIO DATE
F 314	Continued From page	e 7	F 3	4			
	was lying on her back R9 stated that every to to be conducted and twice that day. During continuous ob 7:00 a.m. until 10:30 minutes R9 remained offer to change positie On 8/3/16, at 7:45 a.r was observed to enter for R9's roommate. A care had yet been pro R9 continued lying or the social service's as R9's room for the bre tray was delivered at informed the surveyo taken place since 5:0 shift staff had done it. had offered reposition administered morning the surveyor that she	m. nursing assistant (NA)-B er the room to provide care t 8:04 a.m., NA-B verified no ovided for R9 that morning. n back in bed. At 8:27 a.m., ssistant (SSA)-B entered akfast order. R9's breakfast 8:43 a.m. At 9:54 a.m. R9 r that no postioning had 0 a.m. or so, since the night . R9 stated no day shift staff		timely reposition Residents are repositioning up and with signific plans being up the facility's con review meeting Audits for repose 5x/week x 4 we decrease to 3x, satisfactory will weeks and there deems unnecess The Director of responsible for	reviewed for skin risk and pon admission, quarterly cant change with care dated as needed through mprehensive care plan g. sitioning will be completed eeks, if satisfactory will /week x 2 weeks, if I decrease to weekly x 4 n quarterly until QAPI tear ssary.		
	or so, and "feels stiff. the resident to use th The director of nursin call light and R9 infor repositionig was need and NA-D entered the morning cares. R9's 6/2/16, Minimum the resident required with cares including r	positioned was at 5:00 a.m. " The surveyor encouraged e call light to ask for help. g (DON) responded to R9's med the DON that ded. At 10:24 a.m., NA-B e resident's room to provide an Data Set (MDS) indicated extensive to total assistance epositioning. The MDS had moderate cognitive					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/01/2016 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245340	B. WING		_	C 08/04/2016	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
GALTIER I	HEALTH CENTER			445 GALTIER AVENUE SAINT PAUL, MN 5510	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	ulcer risk was noted, ulcers at Stage 1 or g A nurse practitioner's revealed the resident factors including mort multiple sclerosis, and the NP's notes indicat surgical flap for press subsequent graft failui indicated R9 had bee had subsequently bee on 5/26/16. Document review of a 7/21/16, directed staff R9 to keep back and three times daily. Document review of a Toileting/Repositionin indicated R9 had bee There was no subseq R9 was repositioned to Uning and Reposition when in bed. When interviewed on registered nurse (RN)	t reject cares. A pressure with unhealed pressure reater. (NP) note dated 7/20/16, had pressure ulcer risk bid obesity, diabetes, d malnutrition. In addition, ted the resident had a ure ulcers 3/19/16, with re. The medical record n hospitalized 4/10/16, and en re-admitted to the facility a physician's order dated to provide repositioning for buttock open to air at least a form dated 8/3/16, titled, g Monitoring Worksheet n repositioned at 5:30 a.m. uent documentation to show that morning. he policy dated 7/15, titled, poning Program, directed staff residents every 1-2 hours 8/4/16 at 10:24 a.m.,	F 3	14			
F 315 SS=D			F 3	15			9/13/16

Facility ID: 00480

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	: 09/01/2016 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245340	B. WING		08/	C 04/2016
NAME OF PF	ROVIDER OR SUPPLIER		S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH CENTER		44	45 GALTIER AVENUE		
GALIIEKI	HEALTH GENTER		S	AINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 315	resident's clinical come catheterization was ne who is incontinent of the treatment and service infections and to restor function as possible. This REQUIREMENT by: Based on observation review, the facility failu- incontinence care for reviewed for incontine Findings include: R89 was assessed as to dementia according assessment (CAA)and with activities of daily redirection and reappi During an observation and again 8/3/16, at 8 urine odors permeatin room area. When interviewed on licensed practical nurs independently toileted During an interview of complained the staff of	t's comprehensive ty must ensure that a ne facility without an not catheterized unless the dition demonstrates that ecessary; and a resident oladder receives appropriate is to prevent urinary tract ore as much normal bladder is not met as evidenced in, interview, and document ed to provide appropriate 1 of 1 resident (R89) ence care. is moderate cognition related g to the 6/27/16 care area d required staff assistance living (ADL's) with roach for refusals. in on 8/2/16, at 10:29 a.m. is:40 a.m. there were strong ing on R89's person and a 8/3/16, at 8:45 a.m. se (LPN)-A reported [R89]	F 315	R89 will have a new 3 day voiding dia and bladder assessment completed. Care plan will be updated to reflect cur toileting needs. Residents requiring assistance with incontinent needs will have bladder assessments, care plans and care delivery guides reviewed and revised a necessary. Nursing staff to be reeducated on toilet and providing incontinence care. Resident status of toileting needs to include, but not limited to incontinent c will be reviewed upon admission, quar and with any significant change in statu through the facility's comprehensive ca plan review meeting. Audits will be completed on toileting ar incontinence care 5x/week x 4 weeks, satisfactory will decrease to 3x/week x weeks, if satisfactory will decrease to	rent is ing are erly us ire id	

Facility ID: 00480

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 245340 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 445 GALTIER AVENUE GALTIER HEALTH CENTER SAINT PAUL, MN 55103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 315 Continued From page 10 F 315 no good to turn on the call light for help and boldly weekly x 4 weeks and then quarterly until stated, "they won't help me." QAPI team deems unnecessary. During an observation of a wound dressing Audit results will be reported at the change by LPN-A on 8/3/16, at 9:36 a.m. R89 monthly QAPI meeting. reported the need to urinate. LPN-A asked. "Do you need any help?" to which the resident replied, The Director of Nursing will be "I do." R89's brief was soaked with a large responsible for monitoring for compliance. amount of urine. A clean brief was provided, but LPN-A did not encourage the resident to use the toilet although R89 had reported the need to urinate. In addition, pericare was not offered or provided, and a urine odor was still detected following the brief change. Document review of the 7/10/15 form, titled, Plan of care, directed R89 was occasionally to frequently incontinent of urine. Goals for the resident included free of odor related to bladder incontinence, cooperate with the use of incontinent products, and will be clean and dry with the use of incontinence products. The care plan directed staff to provide and assist R89 with pericare after each incontinence episode as resident allowed. The nursing assistant assignment sheet directed staff to prompt the resident to use the toilet every two hours. R89's 6/21/16, Minimum Data Set (MDS) revealed the resident had moderate cognitive impairment, was frequently incontinent of bladder but was not on a prompted voiding program, and did not reject care during the assessment period. Registered nurse (RN-B) was interviewed on 8/4/16, at 10:00 a.m. RN-B explained that R89 was sometimes "difficult" when approached for cares, however, one staff should have been assisting the resident with pericare when

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY			
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	COMPLETED			
		245340	B. WING		C			
NAME OF P	ROVIDER OR SUPPLIER	240040		STREET ADDRESS, CITY, STATE, ZIP CODE	08/04/2016			
				445 GALTIER AVENUE				
GALTIER	HEALTH CENTER			SAINT PAUL, MN 55103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETI			
F 315	Continued From page changing the brief.	9 11	F 31	5				
F 406 SS=D	Alteration in Urinary C identify urinary proble appropriate for the re- 483.45(a) PROVIDE/	irected staff to utilize the Continence Care Plan to ms, goals, and interventions	F 40	6	9/13/16			
	not limited to, physica pathology, occupation health rehabilitative s and mental retardatio resident's comprehen must provide the required services from accordance with §483	tative services such as, but al therapy, speech-language nal therapy, and mental ervices for mental illness n, are required in the sive plan of care, the facility uired services; or obtain the n an outside resource (in 8.75(h) of this part) from a d rehabilitative services.						
	by: Based on document facility did not provide for 1 of 1 resident (RS preadmission screeni Findings include: Admission record rev admitted on 3/24/16, Down syndrome and Report Level II Pread dated 3/28/16, listed ' diagnosis for this resi			R99's Level II Preadmission Screenin has been redone. Completed 8/24/16 R99's care plan has been updated wit interventions to address any special needs related to qualifying Level II diagnosis. Completed 8/24/16. Resident's medical reocrds were audit for Preadmission screening and the ne for active treatment. Completed 8/19/ Care plans have been updated as needed.	h h ied eed			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
DIEANOI	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING		C	
		245340	B. WING		08/04/2016	
IAME OF PI	ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
BALTIER	HEALTH CENTER			145 GALTIER AVENUE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET	
F 406	Continued From page		F 406			
	assures that all active specified in this perso and will be met while nursing facility." The	eatment. The local agency e treatment needs have been on's individual service plan this person resides in the current plan of care, dated		Social worker will audit new reside an ongoing basis for indications th active treatment is required during Comprehensive Care Plan Review	at J	
	worker (SS)-A was as			Audit results will be reported in the monthly meeting x 3 months or un deemed necessary to monitor compliance. The Director of Social Services wi	til	
	could not locate docu treatment for R99. T facility's procedure for for residents with a L Screening that determ needed. SS-A stated not have a procedure	Imentation of active he surveyor asked for the r providing active treatment evel II Preadmission nined active treatment was I that the facility currently did to provide the active as something the facility		responsible to monitor compliance		
F 431 SS=D	Section 3.5.1 of the fa Screening policy, dat "Provide specialize indicates that it is req 483.60(b), (d), (e) DF LABEL/STORE DRU	d services, if Level II uired." RUG RECORDS,	F 431		9/13/16	
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliation records are in order a	loy or obtain the services of t who establishes a system and disposition of all ifficient detail to enable an n; and determines that drug and that an account of all aintained and periodically				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 09/01/2016 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245340	B. WING		-	08/	C 04/2016
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
GALTIER	HEALTH CENTER			445 GALTIER AVENUE SAINT PAUL, MN 55103			
				-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page	: 13	F 43	31			
		e with currently accepted s, and include the y and cautionary					
	facility must store all o locked compartments	ate and Federal laws, the drugs and biologicals in under proper temperature nly authorized personnel to eys.					
	controlled drugs listed Comprehensive Drug Control Act of 1976 and abuse, except when t package drug distribu	ompartments for storage of					
	by: Based on observation review, the facility fail were stored properly in reviewed for medication	n, interview and document ed to ensure medications in one of two med carts on storage, involving 3 nd R74) of 33 residents.		Resident R6 Comb eye drops were date opened dates equal medication refill date Resident R56 Dorzo	ed with the date I to the day of the e.		
	Findings include:			drops were removed cart and reordered.	•		
	-	uring medication storage ed to date medications such alers when opened.		Resident R74 Proai the cart.	r was removed from	ı	
	During the medication	storage tour on 8/2/16 at		Medication storage	procedures will be		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245340 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 445 GALTIER AVENUE GALTIER HEALTH CENTER SAINT PAUL, MN 55103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 431 Continued From page 14 F 431 3:15 p.m., with licensed practical nurse (LPN)-C reviewed with the licensed nurses and on the fourth floor unit medication cart, TMA's observations included the following: Medication carts will be audited for proper R6's combigan 0.2%-0.5% eye drops (a dates open documentation 2x/week x 4 glaucoma eve drop) and Olopatadine Hcl 0.1 % weeks, if satisfactory will decrease to eye drops (for allergic conjunctivitis) was open weekly x 4 weeks, if satisfactory will and was undated. decrease to monthly x 3 months and if R56's Dorzolamide-Timolol 22.3-6.8/1 drops results are satisfactory will decrease to quarterly. (increase eye pressure) was open and was undated. R74's Proair HFA (rescue inhaler for asthma) Audit results will be reported at the was open and was undated. monthly QAPI meeting. On 8/2/16 3:30 p.m. with Licensed Practical The Director of Nursing is reponsible to Nurse (LPN)-C verified the medications were still monitor compliance. available for resident use and were opened and undated and indicated items would be removed and reordered. On 8/4/16 at 1:25 p.m. the director of nursing acknowledged the medications should be dated when opened and verified she would follow up to see that the medications had been removed and reordered. Policy provided titled "Storage and Expiration of medications, biologicals syringes and needles " indicated under bullet 5. " Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. F 441 483.65 INFECTION CONTROL, PREVENT F 441 9/13/16 SPREAD, LINENS SS=E

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 09/01/2016

ERVICES /SUPPLIER/CLIA TION NUMBER: 245340	A. BUILDING				0.0938-0391	
245340		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	B. WING		_		; 04/2016	
	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
			3			
EDED BY FULL	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE	
	F 441					
d to provide a ironment and nd transmission tion Control ents infections as isolation, esident; and and corrective gram solation to facility must yees with a skin lesions r their food, if ase. wash their ntact for which oted						
	245340 FICIENCIES EDED BY FULL BINFORMATION) Intain an d to provide a ironment and nd transmission tion Control rents infections n as isolation, resident; and and corrective gram solation to a facility must yees with a skin lesions or their food, if ase. o wash their ontact for which pted cess and he spread of	FICIENCIES EDED BY FULL INFORMATION) F 441 Intain an d to provide a ironment and nd transmission tion Control rents infections in as isolation, resident; and and corrective gram solation to e facility must yees with a skin lesions or their food, if ase. o wash their intact for which pted	STREET ADDRESS, CITY, ST 445 GALTIER AVENUE SAINT PAUL, MN 55103 PROVIDERS PREFIX CROSS-REFERENT CROSS-REFERENT CROSS-REFERENT CROSS-REFERENT CROSS-REFERENT F 441 TAG F 441 Tag F 441 Tag F 441 Tag F 441 Tag F 441 Tag F 441 Tag F 441 F 4	STREET ADDRESS, CITY, STATE, ZIP CODE 445 GALTIER AVENUE SAINT PAUL, MN 55103 FICIENCIES EVEND BY FULL INFORMATION) FF 441 Intain an d to provide a irronment and nd transmission tion Control rents infections as isolation, resident; and and corrective gram solation to a facility must yees with a skin lesions or their food, if ase. owash their intact for which pted	street ADDRESS, CITY, STATE, ZIP CODE 445 GALTIER AVENUE SAINT PAUL, MN 55103 FICIENCIES ENDED BY FULL SINFORMATION) F 441 Intain an d to provide a irronment and nd transmission tion Control tents infections as isolation, resident; and and corrective gram solation to f facility must yees with a skin lesions ry their food, if ase. wash their intact for which pted	

Facility ID: 00480

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	L 1	E SURVEY IPLETED
			A. BUILDING			С
		245340	B. WING		08/04/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
• • •				445 GALTIER AVENUE		
GALTIER	HEALTH CENTER			SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 441	Continued From page		F 44	1		
		Γ is not met as evidenced				
	by: Based on observation	on, interview and document		LPN A was immediately in servic	red on	
		led to implement procedures		proper infection control technique		
		or the spread of infection		a dressing change.	aanng	
		or 2 of 2 residents (R89, R9)		5		
		care, and to implement		Nursing staff on duty were reedu	cated	
		nt the spread of infection		immediately on proper infection of		
	during blood glucose			technique during a dressing char	nge on	
		observed who required blood		8/3/16.		
	glucose monitoring.			The licensed nurses will be reed	upstad on	
	Findings include:			infection control and dressing cha		
					unges.	
	During an observatio	n on 8/3/16, at 8:59 a.m.		The nursing staff will be reeducated	ted on	
	-	g from the right shin had		appropriate times to wash hands		
		kle area. During interview		change gloves.		
		veyor of "going downstairs				
		ned not asking for help, as		Audits will be conducted on clear		
	the staff "won't help r	-		dressing changes for proper infe		
		he call light to summon		control techniques 3x/week x 4 w		
		practical nurse LPN-A she would change the wound		satisfactory will decrease audits t x 4 weeks, if satisfactory will dec		
		she would change the would carrying a page from R89's		audits to monthly x 3 months.	0.000	
		hich was placed on the				
		e table next to the dressing		Education was initiated during the	e survey	
		the normal saline bottle used		on the procedure for Glucose Mo		
	for cleansing the wou	und. LPN-A informed R89		Equipment 8/3/16.	-	
		supplies to complete the				
		subsequently left the room.		Licensed nurses and TMA's will I		
		y other day the dressing		educated on cleaning procedure		
	- · ·	d per self, without staffs'		frequency of cleaning blood gluce	ose	
		they did not care. At 9:15 ed room with supplies and		monitoring machines.		
		change. R89 reported to		Audits will be conducted on appr	opriate	
		not performing the dressing		procedure and frequency of gluce		
		cated she would let staff		cleaning 3x/week x 4 weeks, if re		
	-	ern. LPN-A washed hands,		satisfactory will decrease audits		
		ut plastic under R89's foot		x 4 weeks, if results are satisfact	•	

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				PLE CONSTRUCTION	OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G	(X3) DATE SURVEY COMPLETED
					с
		245340	B. WING		08/04/2016
NAME OF P	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZI	P CODE
	HEALTH CENTER			445 GALTIER AVENUE	
OALIILK				SAINT PAUL, MN 55103	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE
F 441	Continued From page	e 17	F 44	41	
	removal of the partial dressing covering the scissors from R89's p cut off soiled dressing cleaning of the wound LPN-A handed it to R gloves. LPN-A then p R89's wound. LPN-A used to cut off the soi gauze to wrap the Tey removed gloves, was contaminated scissor container, and left the medication sheet to m A physician progress R89's diagnoses inclu wound with history of cancer): "Culture per growing staph [bacter completed a course of Treatment record for change R89's dressin showed multiple refus	personal supply container to g around the ankle. During d R89 requested a hat which 89, contaminating the same roceeded to apply powder to used the same scissors iled dressing to cut clean gaderm dressing. LPN-A hed hands, returned is into clean dressing e room to return the		decrease audits to mont and if results are satisfac decrease audits to quart Audit results will be repo monthly QAPI meeting. The Director of Nursing i monitor compliance.	ctory will erly. rted at the
	the resident had oper dressings. Additional	Set on 6/21/16, indicated n lesions with applications of y, the assessment noted the rely impaired cognition, but			
	8/4/16, at 10:24 a.m. have ensured R89's of wound care should ha	 B was interviewed on and verified staff should dressings were intact, and ave been provided in a d healing following the 			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/01/2016 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245340	B. WING		-	08/0	04/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GALTIER	HEALTH CENTER			45 GALTIER AVENUE SAINT PAUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page facility's infection cont R9 did not receive infe cares and dressing ch During an observation R9 was assisted with care by nursing assist LPN-A. Neither NA wa donning gloves and g bath. At 10:35 a.m. Lf dressing change. LPN hand washing/sanitizi supplies in a container gauze and dressing fe dressing container wh gloved hands and pla not remove her gloves touching the floor. LP treatment sheets whice contaminated book th prior to the observation from inside the wound dressing, and then pro- wearing contaminated dressing supplies from nurse (RN)-A then em the ending of the bed RN-A advised NA's to gloves since they had resident. In addition, f would need to discard NA-D had used her gloves	e 18 rol policies. ection control standards with hange n on 8/3/16, at 10:24 a.m. repositioning and wound cant (NA)-D, NA-B and ashed hands prior to iving the resident a bed PN-A entered room to do I-A donned gloves without ing and brought dressing r to the bedside. Clean ell onto the floor from hich LPN-A picked up with ced on a chair. LPN-A did is and wash her hands after N-A brought in 4 pages of the were placed on top of a e resident had been reading in. LPN-A removed packing d, disposed of the soiled poceeded to finger through d gloves to obtain clean in the container. Registered tered room and observed bath and dressing change. wash hands and don new performed pericare for the RN-A informed the staff they I the medicated cream, as	F 441	D			
		es, and was advised to					

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	D: 09/01/2016 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245340	B. WING			C 08/04/2016	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIER HEALTH CENTER				445 GALTIER AVENUE SAINT PAUL, MN 55103		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
treatment sheets sho R9's personal items is should not have place medicated cream com- proper hand washing procedures had not be dressing change. Wound care and infe- requested, but were R3 and R47 received on 08/02/16 before th practical nurse (LPN) glucose monitor for be properly cleaning before a going to check two re- performed on resider diabetes). LPN-B reformed on resider diabetes). LPN-B reformed on resider diabetes). LPN-B reformed on resider diabetes). LPN-B reformed on resider diabetes. LPN-B reformed on resider resident. LPN-B reformed on resider resid	ation, RN-A verified the puld not have been placed on in the room and the NA ed her soiled glove into the intainer. RN-A also verified and dressing change been followed during R9's ction control policies were not provided. d blood glucose monitoring he lunch meal and licensed)-B used the same blood both residents without tween use. .m. LPN-B indicated was esident's blood sugars (test ht with diagnoses of trieved a blood glucose kept in a small plastic tote bom. At the completion of st, LPN-B took the tote	F	441			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 09/01/2016 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245340	B. WING		-	C 08/04/2016		
NAME OF PROVIDER OR SUPPLIER				STF	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
GALTIER HEALTH CENTER				445 GALTIER AVENUE				
				SA	INT PAUL, MN 55103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T			ON SHOULD BECOMPLETIONIE APPROPRIATEDATE		
F 441	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 LPN-B verified the blood glucose monitor was not cleaned after use in between residents and should have been cleansed with the provided antibacterial, antiviral wipes. LPN-B indicated being nervous and forgot to cleanse the monitor. On 8/3/16 at 8:15 a.m., the director of nursing verified the blood glucose monitor should be cleansed with a disinfectant wipe per manufacturing guidelines in between residents and verified there had just been some teaching on the subject. The infection control policy and procedure for glucose monitoring equipment, dated 7/2015 was provided on 8/3/16 at 8:45 a.m. by the director of nursing. The policy indicated, "Disinfect the glucometer with the wipes following use on each resident. The center provides a safe and effective process for decontaminating glucometer's after each use on each resident " Procedure Bullet Cleaning the Glucometer reads as follows; " 1. Use the disinfectant wipe to clean all external parts of the glucometer with gloves on a. A specific amount of wet contact time is not required for first cleaning after the blood glucose test 2. Remove gloves 3. Perform hand hygiene 4. Don clean gloves, 5. Obtain a second wipe and fresh paper towel 6. Use the wipe to clean all external parts of the glucometer on the fresh paper towel A. allow the meter to remain wet for the contact time required by manufacturer's recommendation before completing another glucose test 8. emove gloves 9. Perform hand hygiene 10. Place glucometer in appropriate storage until next blood glucose test."		F 4	41				
F 465	483.70(h)	<u></u>	F 4	·65				9/13/16

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 245340 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 445 GALTIER AVENUE GALTIER HEALTH CENTER SAINT PAUL, MN 55103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 465 Continued From page 21 F 465 SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABL **E ENVIRON** The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document The facility will maintain a safe, sanitary and comfortable environment. review, the facility failed to maintain a functional and comfortable environment for 9 of 35 residents (R150, R4, R66, R89, R23, R9, R149, R150's un-cleanable grab bar covering R107, R26) reviewed for environmental concerns. was removed and covering with a Findings include: cleanable surface will be applied upon On 8/3/16, at 1:00 p.m. during the environmental arrival from distributor. tour with the maintenance supervisor (MS), Grab bars will be checked for uncleanable manager housekeeping (MH), manager (M), and district manager (DM), the following concerns covering, if found will be removed and were observed. replaced upon arrival of supply. R150's bed side grab bars had un-cleanable grav foam wrapped and taped around the bars. R4 and R63 bathroom tile was replaced During tour, MS stated the foam was on the rails on 8/10/16. for residents who bump their heads. MS stated if the foam got damaged, maintenance replaced it. The staff is being educated on ensuring M stated it was an un-cleanable surface and if grab bars on the beds are locked. damaged they would replace it. MS indicated it would be an infection control concern if it was in R66's air conditioning unit was replaced an infection control room. 8/24/16. R4's shared bathroom with R63 was observed R9's air conditioner was placed on the air conditioning mode. Maintenance will in with a large worn area in the middle of the floor, directly in front of the toilet. DM stated it was a service on proper use of air conditioners. permanent stain. MS indicated it was on the list to Laminated cards will be placed with be replaced in about one week. instructions in each resident room. R66's room window air conditioner had a large brown knob sticking outward above the controls. R149 had a fan placed in the room on MS stated it was an older air conditioner and 8/22/16.

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 09/01/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 245340 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 445 GALTIER AVENUE GALTIER HEALTH CENTER SAINT PAUL, MN 55103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 465 Continued From page 22 F 465 indicated the piece turned to change the air flow R107's grab bar was locked in place. position. Towel bar in the bathroom was removed R66 had indicated did not think the room was and area was repaired on 8/23/16. always clean and sometimes the bathroom had an odor. MH stated the bathrooms were cleaned R107 has been educated on how to lock daily. M stated rooms were deep cleaned once a the grab bar in place on 8/24/16. month and identified the toilet had not been flushed which could cause the smell. Audits to ensure compliance in the aforementioned areas will be conducted R89 had indicated the building had an odor and 2x/week x 90 days. there was an odor in the room. R89's bedside chair had a large stain in the seat cushion. MH The Maintenance Director will be stated there was a new stain on the room divider responsible for compliance. curtain. DM stated he thought the unattended plants on the window sill could be the cause of Audit results will be reported at the the smell. M stated the room had stagnant air and monthly QAPI meeting. it would help if the air conditioner was turned on. R66 and R 23 bathrooms will be cleaned M confirmed the chair had a stain and stated it would be cleaned that night. daily. R23 had indicated staff did not clean the Housekeeping will refinish the new floor in bathroom daily. MH stated the bathrooms should bathroom of R4 and R63. be cleaned daily. A weekly inspection of the replaced floors R9 had indicated being too hot and had two fans will be done x 3 months and if results are blowing in her direction. The room air conditioner satisfactory will decrease to monthly x 3 was set on high fan instead of high air months. conditioning. MS stated the air conditioner was on R89's room divider curtain and chair were the wrong setting. It was set on high fan, not air conditioning and now the setting was changed so replaced immediately. it was cool in the room. All chairs and room divider curtains will be R149 had stated the room was always warm at checked for stains and replaced as night and the privacy curtain blocked off the air necessary. conditioning and the fan in the room. MS stated he would get a fan installed on the wall in a The halls will be cleaned daily. couple of days and M would follow up to ensure it was done. R89's room will be cleaned daily.

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Facility ID: 00480

If continuation sheet Page 23 of 25

PRINTED: 09/01/2016

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 09 (X3) DATE SURV	/EY		
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETE	D		
		245340	B. WING		C 08/04/2	016		
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODI		010		
GALTIER	HEALTH CENTER			445 GALTIER AVENUE SAINT PAUL, MN 55103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO	(X5) MPLETIO DATE		
F 465	Continued From page	e 23	F4	65				
	stated the grab bar w demonstrated how it or staff could unlock i was it was locked at a R26's bathroom towe broken. MS stated he rack and put new tile On 8/3/16, at 2:03 p.r policy would be provi- paperwork was comp nurse station and rep MS further stated ma provided. On 8/4/16, at 12:50 p on fourth floor unit of stated staff could writ maintenance/housek checked first in the m Maintenance complet be done right away. V staff paged maintena Undated facility 2nd f indicated: "8:00 Begir (using the 5 and 7 step DEEP CLEAN ROON 10:45 Continue clean the 5 and 7 Step Clea Continue cleaning resident roo Cleaning Method)" LIST indicated: "19. C Clean and disinfect s down bathroom pull c	locked in place. The resident it. MS stated his expectation all times. It rack was observed to be a would remove the towel in that area. m. MH stated housekeeping ded. MS stated work order oleted on each floor at the borts given each morning. intenance policy would be m.m. observation was made work order requests. MS te any eeping concerns which he borning on all units. ted those which needed to With immediate concerns, nce. floor housekeeper sheet in cleaning resident rooms ep cleaning method), 10:15 A (from posted schedule), hing resident rooms (Using		Inspections of the room and h will be conducted 5x/week x 1 upon satisfactory results, will o weekly x 6 months. The Director of Housekeeping responsible for compliance. Results of audits/inspections of reported at the monthly QAPI	month, decrease to will be			

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If continuation sheet Page 24 of 25

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/01/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE (COMPL	SURVEY LETED
		245340	B. WING			C 08/0))4/2016
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STA	TE, ZIP CODE		
GALTIER	HEALTH CENTER			445 GALTIER AVENUE SAINT PAUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 465	housekeeper dated 1 housekeeper perform dust mopping and da and sanitizing bathroo and commodes. They daily cleaning and san	/1/2000 indicated: "the light is a variety of tasks, such as mp mopping floors, cleaning oms including sinks, tubs are responsible for the nitizing of patient room busekeeping policy was	F 465				

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Facility ID: 00480

If continuation sheet Page 25 of 25

ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING		E SURVEY PLETED
		245340	B, WING		08/	03/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIER	R HEALTH CENTER			445 GALTIER AVENUE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	кo	000		
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	FIRE SAFETY					
	Minnesota Departn Fire Marshal Divisi time of this survey, found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Saf edition of National	l at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			1	
	PLEASE RETURN CORRECTION FC DEFICIENCIES (K	R THE FIRE SAFETY		EPOC		
	HEALTHCARE FIF	RE INSPECTIONS SHAL DIVISION				

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.

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /		ATE SURVEY
D PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING (01 - MAIN BUILDING	
		245340	B. WING		8/03/2016
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 45 GALTIER AVENUE	
ALTIER	HEALTH CENTER			AINT PAUL, MN 55103	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 000	Continued From pa	age 1	K 000		
	Or by email to: Marian.Whitney@s Angela.Kappenma				
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:			
	1. A description of to correct the defic	what has been, or will be, done iency.			
	2. The actual, or p	oposed, completion date.			
	responsible for cor	er title of the person rection and monitoring to ence of the deficiency			
	Type II(222) constr and is fully fire spri	g was determined to be of ruction. It has a full basement nklered. The facility has a ds. At the time of the survey the			
K 038	NOT MET as evide NFPA 101 LIFE SA	t 42 CFR Subpart 483.70(a) is enced by: AFETY CODE STANDARD	K 038		9/13/16
SS=D	Exit access is arra accessible at all tir 7.1. 19.2.1 This STANDARD Based on observa observed that one	nged so that exits are readily nes in accordance with section is not met as evidenced by: ation and staff interview, it was of several exterior exit nange in grade not in ection 7.1., 19.2.1.		"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."	e not

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CSZD21

Facility ID: 00480

If continuation sheet Page 2 of 4

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY
		245340	B. WING		/03/2016
	PROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 45 GALTIER AVENUE SAINT PAUL, MN 55103	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
	the Northwest exterinch change in gradway that could imp This deficient pract Maintenance Super NFPA 101 LIFE SA Smoking regulation less than the follow (1) Smoking is pro- compartment when combustible gases and in any other ha area is posted with or with the internat (2) Smoking by par responsible is pro- direct supervision. (3) Ashtrays of non design are provide permitted. (4) Metal contained devices into which readily available to permitted. 19.7. This STANDARD	03/2016, it was observed that rior exit sidewalk had a 1 1/2 de leading to the public right-of ose a tripping hazard. tice was verified by the rvisor at the time of inspection. AFETY CODE STANDARD hs are adopted and include no ving provisions: hibited in any room, ward, or re flammable liquids, s, or oxygen is used or stored azardous location, and such a signs that read NO SMOKING ional symbol for no smoking. tients classified as not hibited, except when under hoombustible material and safe id in all areas where smoking is rs with self-closing cover ashtrays can be emptied are all areas where smoking is 4 is not met as evidenced by:	K 038	The Northwest exterior exit sidewalk was repaired on 8/8/16. Concrete was applied to level the grade to even. Outside exit areas will be audited for uneven surfaces on a monthly basis. The Director of Maintenance will be responsible to monitor compliance.	9/13/16
	interview, the facili designated resider NFPA LSC (00) Ec	ations, policy review and staff ty failed to follow policy for the nt smoking in accordance with dition Section 19.7.4, and the policy. This deficient practice esidents.		Self contained cigarette ashtrays were placed in the smoking area and the staff smoking area. The self locking can for the cigarette butt was ordered and will ship 9/19/16 for the resident smoking area.	s

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CSZD21

Facility ID: 00480

If continuation sheet Page 3 of 4

PRINTED: 08/31/2016

manufacture and the second of	10.000 Television in the second second second second	AND HUMAN SERVICES				APPROVED
		& MEDICAID SERVICES				0938-0391 E SURVEY
AND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING		PLETED
		245340	B. WING _		08/	03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
GALTIEF	R HEALTH CENTER			445 GALTIER AVENUE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 066	Continued From pa Findings include: 1. On facility tour be on 8/03/2016, it wa designated employe butts disposed of in combustible materi no metal container device into which a This deficient pract	ige 3 etween 12:30 PM and 4:00 PM s observed that the outside ee smoking area had cigarette	KO		y-Friday	
	567(02-99) Previous Versions	S Obsolete Event ID: CSZD2		Facility ID: 00480		eet Page 4 of 4

Facility ID: 00480

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PRINTED: 08/31/2016



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted August 18, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5340025, H5340040 & H5340041

Dear Mr. Thompson:

The above facility was surveyed on August 1, 2016 through August 4, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaints numbered H5340040 & H5340041. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Galtier Health Center August 18, 2016 Page 2

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 Susanne Reuss, Unit Supervisor at (651) 201-3793.

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,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s) cc: Original - Facility Licensing and Certification File

Minnesot	a Department of Health	1				
		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	
					c	;
		00480	B. WING		08/0	4/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		445 GALTI	ER AVENUE			
GALTIER	HEALTH CENTER	SAINT PAU	JL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEN	TION*****				
	NH LICENSING C	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of find the Minnesota Depart. Determination of whe corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessmitements of the result in the assessmitements of the result in the assessmitements of the runumber and MN Rule.	ther a violation has been				
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	surveyors of this Dep above provider and th orders are issued. Pl electronic plan of corr reviewed these orders they will be completed	nrough August 4, 2016, artment's staff visited the ne following correction ease indicate in your rection that you have s, and identify the date when				
ABORATORY	partment of Health DIRECTOR'S OR PROVIDER/S cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 08/26/16

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
						С
		00480	B. WING		08	/04/2016
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 000	Initial Comments		2 000			
	*****ATTEN	TION*****				
	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					
	that may result from r orders provided that a	earing on any assessments ion-compliance with these a written request is made to a 15 days of receipt of a for non-compliance.				
	surveyors of this Dep above provider and th orders are issued. Pl electronic plan of corr	rrough August 4, 2016, artment's staff visited the ne following correction ease indicate in your ection that you have s, and identify the date when				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
			A. BUILDING:		С	
		00480	B. WING	08	/04/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLET DATE
2 000	Continued From page	e 1	2 000			
	A complaint investigation was also conducted to investigate complaints #H5340040 and #H5340041. As a result the following correction orders are issued. 2 900: MN Rule 4658.0525 subp. 3 2 905: MN Rule 4658.0525 Subp. 4 2 910: MN Rule 4658.0525 Subp. 5 A. B.					
	electronic receipt of S consistent with the M Health Informational http://www.health.sta obul.htm The State delineated on the Mir Health orders being s Although no plan of c State Statutes/Rules "corrected" in the box indicate in the electro under the heading co orders will be correct	ed to participate in the State licensure orders linnesota Department of Bulletin 14-01, available at te.mn.us/divs/fpc/profinfo/inf licensing orders are nnesota Department of submitted electronically. correction is necessary for , please enter the word available for text. Then onic State licensure process, ompletion date, the date your ed prior to electronically nesota Department of				
2 555	MN Rule 4658.0405 Plan of Care; Develo	Subp. 1 Comprehensive pment	2 555			
	must develop a comp each resident within a completion of the cor assessment as define comprehensive plan by an interdisciplinan	opment. A nursing home prehensive plan of care for seven days after the nprehensive resident ed in part 4658.0400. The of care must be developed y team that includes the a registered nurse with				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C	
			A. BUILDING:			
		00480	B. WING		08	5/04/2016
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From page	2	2 555			
	 ^{2 555} Continued From page 2 responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive plan of care including required active treatment for 1 of 1 resident (R99) reviewed for preadmission screening. 					
	Findings include:					
	admitted on 3/24/16, Down syndrome and Report Level II Pread dated 3/28/16, listed diagnosis for this resi Treatment section of does require active tr assures that all active specified in this perso and will be met while					
	worker (SS)-A was as active treatment for R could not locate docu treatment for R99. T	he surveyor asked for the r providing active treatment evel II Preadmission				

STATEMEN	ta Department of Healt T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
			A. BUILDING:			С
		00480	B. WING		08	/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From page	e 3	2 555			
	needed. SS-A stated that the facility currently did not have a procedure to provide the active treatment, and this was something the facility needed to develop going forward.					
	The director of nursir review and revise po to ensuring care plan individual resident. T designee could deve and develop a monito	OD OF CORRECTION: Ig (DON) or designee could licies and procedures related development for each The director of nursing or lop a system to educate staff oring system to ensure staff nprehensive written plan of				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 840	MN Rule 4658.0520 Proper Nursing Care	Subp. 2 B Adequate and ; Clean skin	2 840			
		determining adequate and teria for determining care include:				
	odors. A bathing plat resident's plan of car condition requires that must be given a com other day and more of incontinent resident r	at the resident remain in bed plete bath at least every often as indicated. An nust be checked at least must receive perineal care				
	[144A.04 Subd. 11. Notwithstanding Minr 4658.0520, an incont	-				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMF	SURVEY
			A. BUILDING:		с	
		00480	B. WING		08	/04/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
	 2 840 Continued From page 4 checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the 					
s t c c c c c r r t t E r i i r	skin to prevent irritat types of protectors n completely covered, contact with the resid clothing must be rem resident areas to pre This MN Requirement by:	ion. Rubber, plastic, or other nust be kept clean, be and not come in direct dent. Soiled linen and noved immediately from event odors.				
	review, the facility fa	n, interview, and document iled to provide appropriate r 1 of 1 resident (R89) hence care.				
	R89 was assessed a to dementia accordir					

STATE FORM

STATEMEN	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		00480	B. WING		08	C 3/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE			
		SAINT F	PAUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pag	e 5	2 840			
	and again 8/3/16, at	n on 8/2/16, at 10:29 a.m. 8:40 a.m. there were strong ng on R89's person and				
		n 8/3/16, at 8:45 a.m. rse (LPN)-A reported [R9] d herself.				
	During an interview on 8/3/16, at 8:59 a.m. R89 complained the staff did not provide assistance and she had to do everything for herself. R89 said it did no good to turn on the call light for help and boldly stated, "they won't help me."					
	change by LPN-A on stated she needed to you need any help?" "I do." R89's brief wa amount of urine. A cl LPN-A did not encou toilet although she ha urinate. In addition, p	n of a wound dressing 8/3/16, at 9:36 a.m. R89 o urinate. LPN-A asked, "Do to which the resident replied, is soaked with a large ean brief was provided, but rage the resident to use the ad reported she needed to bericare was not offered or sident continued to smell of ief change.				
	of care, directed R88 frequently incontinent resident included free incontinence, cooper incontinent products, with the use of incon- plan directed staff to pericare after each in resident allowed. The	and will be clean and dry tinence products. The care provide and assist R89 with ncontinence episode as				

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
			A. BUILDING:			
		00480	B. WING		C 08/04/2016	
AME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE		
BALTIER	HEALTH CENTER					
0(0)15			AUL, MN 55103	PROVIDER'S PLAN C		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
2 840	Continued From page	e 6	2 840			
	impairment, was freq but was not on a pror did not reject care du Registered nurse (RN 8/4/16, at 10:00 a.m. was sometimes "diffic cares, however, one assisting the resident changing the brief. The facility's 7/15, Ma Incontinence policy d Alteration in Urinary (had moderate cognitive uently incontinent of bladder npted voiding program, and ring the assessment period. N-B) was interviewed on RN-B explained that R89 cult" when approached for staff should have been with pericare when anagement of Urinary irected staff to utilize the Continence Care Plan to ems, goals, and interventions				
	The director of nursin review and revise pol to ensuring appropria to incontinence. The designee could devel and develop a monito are providing this car	OD OF CORRECTION: g (DON) or designee could icies and procedures related te care and services related director of nursing or op a system to educate staff oring system to ensure staff e. CORRECTION: Twenty-one				
2 900		Subp. 3 Rehab - Pressure	2 900			
	Subp. 3. Pressure so comprehensive reside of nursing services m	ent assessment, the director				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
			A. BUILDING:			С	
		00480	B. WING		08	3/04/2016	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
BALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From page	e 7	2 900				
	development of a nur provides that:	sing care plan which					
	without pressure sore pressure sores unless condition demonstrate	s the individual's clinical					
	B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.						
	by: Based on observatior review, the facility fail repositioning for 1 of	t is not met as evidenced n, interview, and document ed to provide timely 2 residents (R9) who was ressure ulcer development.					
	Findings include:						
	R9 was assessed as to the minimum data 5/26/16, and required activities of daily living	total assistance with					
	was lying on her back R9 stated that every t	n on 8/1/16, at 5:58 p.m. R9 k in bed. When interviewed, two hour repositioning was had only been repositioned					
	7:00 a.m. until 10:30	servation on 8/3/16, from a.m. three hours and thirty I lying on back without an on.					

STATE FORM

STATEMENT	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			С
		00480	B. WING		08	8/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE			
	1		AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	e 8	2 900			
	was observed to enter for R9's roommate. A care had yet been pro R9 continued lying or the social service's a R9's room for the breat tray was delivered at informed the surveyot taken place since 5:00 shift staff had done it had offered reposition administered morning the surveyor that she any cares that day. A the last time being re or so, and "feels stiff. the resident to use th The director of nursin call light and R9 infor repositionig was need and NA-D entered the morning cares.	g medications, LPN-A told had not assisted R9 with t 10:08 a.m. R9 again said positioned was at 5:00 a.m. " The surveyor encouraged the call light to ask for help. ng (DON) responded to R9's med the DON that ded. At 10:24 a.m., NA-B e resident's room to provide				
	the resident required with cares including r further indicated R9 h impairment but did no	n Data Set (MDS) indicated extensive to total assistance repositioning. The MDS had moderate cognitive bt reject cares. A pressure with unhealed pressure greater.				
	revealed the resident factors including mor multiple sclerosis, an the NP's notes indica surgical flap for press subsequent graft failu	(NP) note dated 7/20/16, t had pressure ulcer risk bid obesity, diabetes, d malnutrition. In addition, tted the resident had a sure ulcers 3/19/16, with ure. The medical record en hospitalized 4/10/16, and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:		с		
		00480	B. WING		30	08/04/2016	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE			
BALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From page	9	2 900				
	had subsequently bee on 5/26/16.	en re-admitted to the facility					
	7/21/16, directed staf	a physician's order dated f to provide repositioning for buttock open to air at least					
	Document review of a form dated 8/3/16, titled, Toileting/Repositioning Monitoring Worksheet indicated R9 had been repositioned at 5:30 a.m. There was no subsequent documentation to show R9 was repositioned that morning.						
	Turning and Reposition	he policy dated 7/15, titled, oning Program, directed staff residents every 1-2 hours					
		8/4/16 at 10:24 a.m.,)-B verified the facility 9 to be repositioned every					
	The director of nursin all residents at risk fo they are receiving the treatment/services to from developing and pressure ulcers. The designee, could cond delivery of care; to en	prevent pressure ulcers					
		pment and to promote					
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:		С	
		00480	B. WING		08/04/2016	
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
ALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLET
2 905	MN Rule 4658.0525	Subp. 4 Rehab - Positioning	2 905			
	of residents unable to	. Residents must be ody alignment. The position o change their own position east every two hours,				
	including periods of t been put to bed for th has documented that hours during this time	ime after the resident has ne night, unless the physician t repositioning every two e period is unnecessary or lered a different interval.				
	by: Based on observation review, the facility fai repositioning for 1 of	nt is not met as evidenced n, interview, and document led to provide timely 2 residents (R9) who was ressure ulcer development.				
	Findings include:					
	to the minimum data	cognitively intact according set (MDS) admission d total assistance with g.				
	was lying on her back R9 stated that every	n on 8/1/16, at 5:58 p.m. R9 k in bed. When interviewed, two hour repositioning was had only been repositioned				
	7:00 a.m. until 10:30	oservation on 8/3/16, from a.m. three hours and thirty d lying on back without an on.				
		m. nursing assistant (NA)-B er the room to provide care				

STATE FORM

STATEMENT	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		00480	B. WING		30	C 3/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER					
			AUL, MN 55103			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 905	Continued From page	e 11	2 905			
	care had yet been pro R9 continued lying or the social service's as R9's room for the bre tray was delivered at informed the surveyo taken place since 5:0 shift staff had done it had offered reposition administered morning the surveyor that she any cares that day. A the last time being re or so, and "feels stiff. the resident to use th The director of nursin call light and R9 infor repositionig was need	g medications, LPN-A told had not assisted R9 with t 10:08 a.m. R9 again said positioned was at 5:00 a.m. " The surveyor encouraged e call light to ask for help. ng (DON) responded to R9's				
	the resident required with cares including r further indicated R9 r impairment but did no	n Data Set (MDS) indicated extensive to total assistance epositioning. The MDS nad moderate cognitive ot reject cares. A pressure with unhealed pressure greater.				
	revealed the resident factors including mort multiple sclerosis, and the NP's notes indica surgical flap for press subsequent graft failu indicated R9 had bee	(NP) note dated 7/20/16, had pressure ulcer risk bid obesity, diabetes, d malnutrition. In addition, ted the resident had a sure ulcers 3/19/16, with ure. The medical record en hospitalized 4/10/16, and en re-admitted to the facility				

Minnesota Department of Health

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:		С	
		00480	B. WING		08/04/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 905	Continued From page	e 12	2 905			
	7/21/16, directed staf	a physician's order dated ff to provide repositioning for buttock open to air at least				
	Toileting/Repositionir indicated R9 had bee	a form dated 8/3/16, titled, ng Monitoring Worksheet en repositioned at 5:30 a.m. quent documentation to show that morning.				
	Turning and Repositi	the policy dated 7/15, titled, oning Program, directed staff residents every 1-2 hours				
	registered nurse (RN	8/4/16 at 10:24 a.m.,)-B verified the facility R9 to be repositioned every				
	The director of nursin review and revise pol to ensuring appropria repositioning of resid or designee could de	ents. The director of nursing velop a system to educate nonitoring system to ensure				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 910	MN Rule 4658.0525 Incontinence	Subp. 5 A.B Rehab -	2 910			
	Subp. 5. Incontinenc	ce. A nursing home must				
nesota Dep TE FORM	partment of Health		, ,			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:				
		00480	B. WING		08	C 08/04/2016	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
ALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	D THE APPROPRIATE	COMPLET DATE	
2 910	Continued From page	e 13	2 910				
	have a continuous pr	ogram of bowel and bladder					
	÷	ce incontinence and the					
		atheters. Based on the					
	comprehensive reside	ent assessment, a nursing at:					
		enters a nursing home					
		catheter is not catheterized					
1		clinical condition indicates					
	that catheterization w						
		is incontinent of bladder					
		treatment and services to infections and to restore as					
		function as possible.					
	This MN Requiremen by:	t is not met as evidenced					
		n, interview, and document					
		ed to provide appropriate					
	incontinence care for reviewed for incontine						
	Findings include:						
		s moderate cognition related					
		g to the 6/27/16 care area					
		d required staff assistance					
	with activities of daily redirection and reapp						
	During an observation	n on 8/2/16, at 10:29 a.m.					
		3:40 a.m. there were strong					
		ng on R89's person and					
	room area.						
	When interviewed or	1 8/3/16, at 8:45 a.m.					
		se (LPN)-A reported [R89]					
	independently toileted						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		с	
		00480	B. WING		08/04/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 910	Continued From page	e 14	2 910			
	complained the staff of and had to do everyth no good to turn on the stated, "they won't he During an observation change by LPN-A on reported the need to you need any help?" "I do." R89's brief was amount of urine. A cle LPN-A did not encoun toilet although R89 ha urinate. In addition, p provided, and a urine following the brief cha Document review of to of care, directed R89 frequently incontinent resident included free incontinence, coopera- incontinent products, with the use of incont plan directed staff to pericare after each in resident allowed. The	n of a wound dressing 8/3/16, at 9:36 a.m. R89 urinate. LPN-A asked, "Do to which the resident replied, s soaked with a large ean brief was provided, but rage the resident to use the ad reported the need to ericare was not offered or odor was still detected ange. he 7/10/15 form, titled, Plan 9 was occasionally to t of urine. Goals for the e of odor related to bladder ate with the use of and will be clean and dry inence products. The care provide and assist R89 with continence episode as e nursing assistant ected staff to prompt the ilet every two hours.				
	revealed the resident impairment, was freq but was not on a pror	had moderate cognitive uently incontinent of bladder npted voiding program, and ring the assessment period.				
		J-B) was interviewed on RN-B explained that R89				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C 08/04/2016	
			A. BUILDING:			
		00480	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From pag	je 15	2 910			
	cares, however, one	icult" when approached for staff should have been it with pericare when				
	Incontinence policy of Alteration in Urinary	lanagement of Urinary directed staff to utilize the Continence Care Plan to ems, goals, and interventions esident.				
	The director of nursi review and revise po to ensuring appropri- to incontinence. The designee could deve	HOD OF CORRECTION: ng (DON) or designee could blicies and procedures related ate care and services related e director of nursing or elop a system to educate staff oring system to ensure staff re.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			
	control program mus procedures which pr A. surveillance to collection to identify residents; B. a system for control of outbreaks	nd procedures. The infection st include policies and ovide for the following: based on systematic data nosocomial infections in detection, investigation, and of infectious diseases;				
	reduce risk of transn D. in-service ed prevention and contr	precautions systems to nission of infectious agents; ucation in infection rol; alth program including an				

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			С
		00480	B. WING	08	3/04/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page	e 16	21390			
	defined in part 4658. procedures of resident the prevention and tr F. the developme employee health poli practices, including a defined in part 4658. G. a system for r Products which affect disinfectants, antisep incontinence product I. methods for m	eviewing antibiotic use; eview and evaluation of t infection control, such as tics, gloves, and				
	by: Based on interview a facility failed to docur tuberculosis (TB) skin for 3 of 5 residents (F for TB screening. The medical evaluation w residents (R23) with facility failed to ensur Screening Tool for Ne Care Home Resident and based on observ document review, the procedures to minimi infection during wour (R89, R9) observed f implement procedure	e facility failed to implement ze the risk for the spread of id care for 2 of 2 residents for wound care, and to es to prevent the spread of d glucose monitoring for 2 of) observed who required				

	a Department of Healt TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:			С	
		00480	B. WING			B/04/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, 2	ZIP CODE			
GALTIER	HEALTH CENTER		LTIER AVENUE PAUL, MN 55103				
()(1)10		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLET DATE	
21390	Continued From page	e 17	21390				
	Findings include:						
	R93 was admitted to the facility on 6/26/15, per R93's annual Minimum Data Set (MDS) dated 6/30/16. R93's immunization record dated 6/29/15, revealed R93's 2nd step TST did not have a negative reading. R23 was admitted to the facility on 2/28/14, per R23's quarterly MDS dated 5/31/16. R23's immunization record dated 6/20/13, revealed R23's chest x-ray did not include a physician exam. R23's record indicated R23 received INH treatment around 1990 with no exact date. R124 was admitted to the facility on 1/21/16, per R124's quarterly MDS dated 5/20/16. R124's immunization record dated 1/13/16, revealed R124 did not receive a 2nd step TST.						
	R92's quarterly MDS immunization record	the facility on 2/29/16, per dated 5/12/16. R92's dated 3/16/15, revealed R92 or 2nd step TST reading.					
	informed of the lack of	nterim IDON who was of TB information. The IDON n was the facility follow their					
	dated July 2015 direc administer the two-st Derivative (PPD) Tes required by State Re unless they have doo previous positive skir	ep Mantoux Purified Protein t to all new residents as gulations on admission cumented evidence of a					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY
			A. BUILDING:			
		00480	B. WING		C 08/04/2016	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE
21390	Continued From pag	je 18	21390			
	experiences a positiv test."	experiences a positive reaction to the current skin test."				
	R89, during an obse	rvation on 8/3/16, at 8:59				
	a.m., revealed a wou	und dressing from the right				
		to the ankle area. During				
	interview R89 informed the surveyor of "going downstairs to smoke" and explained not not					
		ne staff "won't help me." The				
		R89 use the call light to				
		Licensed practical nurse				
	-	nd said she would change the N-A was carrying a page from				
	•	eet, which was placed on the				
		te table next to the dressing				
		the normal saline bottle used				
	-	und. LPN-A informed R89				
		supplies to complete the				
	• •	d subsequently left the room.				
		y other day the dressing td per self, without staffs'				
		they did not care. At 9:15				
		ed room with supplies and				
	initiated the dressing	change. R89 reported to				
		e not performing the dressing				
		icated she would let staff				
		cern. LPN-A washed hands, out plastic under R89's foot				
		saline was poured to facilitate				
		ally attached Tegaderm				
	-	e wound. LPN-A used				
		personal supply container to				
		ig around the ankle. During				
		nd R89 requested a hat which R89, contaminating the same				
		proceeded to apply powder to				
	-	A used the same scissors				
		biled dressing to cut clean				
		egaderm dressing. LPN-A				
	removed gloves, was					

STATE FORM

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:	A. BUILDING:		С
		00480	B. WING		30	3/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page	e 19	21390			
	contaminated scisson container, and left the medication sheet to r	e room to return the				
	R89's diagnoses incl wound with history of cancer): "Culture per growing staph [bacte completed a course of Treatment record for change R89's dressin showed multiple refu	note on 7/13/16, revealed uded infection of right leg basal cell carcinoma (skin dermatology previously rial infection]. Patient has of Bactrim [antibiotic]". 7/16/16, directed staff to ng twice daily. Nursing notes sals of dressing change. ted about importance of daily				
	the resident had open dressings. Additional	Set on 6/21/16, indicated n lesions with applications of ly, the assessment noted the tely impaired cognition, but				
	8/4/16, at 10:24 a.m. have ensured R89's wound care should h	N)-B was interviewed on and verified staff should dressings were intact, and ave been provided in a d healing following the trol policies.				
	R9 did not receive in cares and dressing c	fection control standards with hange				
	R9 was assisted with care by nursing assis LPN-A. Neither NA w donning gloves and g bath. At 10:35 a.m. L dressing change. LP	n on 8/3/16, at 10:24 a.m. repositioning and wound stant (NA)-D, NA-B and vashed hands prior to giving the resident a bed PN-A entered room to do N-A donned gloves without ing and brought dressing				

A. BUILDING: C 00480 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COB/04/2016 SALTIER AVENUE SAINT PAUL, MN 55103 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
00480 B.WIN				A. BUILDING:			
DATER HEALTH CENTER Building and beginning and beginnig and beginning and			00480	B. WING		08	
DATER HEALTH CENTR SAINT PAUL, NN 55103 (24) ID PRETX 740 ISMMARY STREMENT OF DEPICIENCIES (CACH DEPICIENT MUST DE PRECIDE NO FULL RESULTIONY OR LISE IDEMIFYING INFORMATION) ID PRETX 740 ID PRECIDENCIAL ACTION RECOMPLATE (CACH DEPICIENT MUST DEPICIENCIES NULL RESULTIONY OR LISE IDEMIFYING INFORMATION) ID PRETX 740 ID PRECIDENCIAL ACTION RECOMPLATE (CACH DEPICIENCY) Construct of CACHECIDEN SHOLL DE CROSS REFERENCED TO THE APPROPRIATE DEPICIENCY) Construct 21390 21390 Supplies in a container to the bedside. Clean gauze and dressing fell onto the floor from dressing container which LPN-A picked up with gloved hands and placed on a chair. LPN-A did not remove her gloves and wash her hands after touching the floor. LPN-A brought in 4 pages of treatment sheets which were placed on top of a contaminated book the resident had been reading prior to the observation. LPN-A removed packing from inside the wound, disposed of the solied dressing supplies from the container. Registered nurse (RN)A then entered room and observed the ending of the bed bath and dressing change. RN-A advised NA's to wash hands and don new gloves since they had performed pericare for the resident. In addition, RN-A informed the staff they would need to discard the medicated cream. as NA-D had used her gloves and was divised to change her gloves and was bre hands. Following the observation, RN-A verified the treatment sheet should not have placed on R9's personal items in the room and the NA should not have placed her solied glove in the the medicated cream container. R-RA Jaso verified proper hand washing and dressing change procedures had no theoremove requested, but were not provided. ID N-A verified heresing change trequested, but were not provided. I	NAME OF PR	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
Print TAO REACH DEPICIENCY MOST BE PRECEDED BY FULL RECOULTINGY OR LSC DENTIFYING INFORMATION) PRETX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Confine 21390 Continued From page 20 supplies in a container to the bedside. Clean gauze and dressing fell onto the floor from dressing container which LPN-A picked up with gloved hands and placed on a chair. LPN-A did not remove her gloves and wash her hands after touching the floor. LPN-A brought in 4 pages of treatment sheets which were placed on top of a contaminated book the resident had been reading prior to the observation. LPN-A meroved packing from inside the wound, disposed of the solied dressing contaminated gloves to obtain clean dressing supplies from the container. Registered nurse (RN-A davised NA'S to wash hands and don new gloves since they had performed pericare for the gloves since they had performed pericare for the resident. In addition, RN-A infinated LPN-A if she had changed gloves and was advised to change her gloves and was hier hands. Following the observation, RN-A verified the treatment sheets should not have been placed on RS's personal items in the room and the NA should net wound. LPN-A verified the treatment sheets should not have been placed on RS's personal items in the room and the NA should not have placed her solied glove into the medicated cream container. RN-A also verified proper hand washing and dressing change procedures had not been followed during R9's dressing change. Wound care and infection control policies were requested, but were not provided. Wound care and infection control policies were requested, but were not provided.	GALTIER I	HEALTH CENTER					
supplies in a container to the bedside. Clean gauze and dressing fell onto the floor from dressing container which LPN-A picked up with gloved hands and placed on a chair. LPN-A did not remove her gloves and wash her hands after touching the floor. LPN-A brought in 4 pages of treatment sheets which were placed on top of a contaminated book the resident had been reading prior to the observation. LPN-A removed packing from inside the wound, disposed of the soiled dressing, and then proceeded to finger through wearing contaminated gloves to obtain clean dressing supplies from the container. Registered nurse (RN)-A then entered room and observed the ending of the bed bath and dressing change. RN-A advised NA's to wash hands and don new gloves since they had performed pericare for the resident. In addition, RN-A informed the staff they would need to discard the medicated cream, as NA-D had used her gloved hand to remove cream from the jar. RN-A then asked LPN-A if she had changed gloves sither removing solied packing from the wound. LPN-A verified the treatment sheets should not have been placed on RP's personal items in the room and the NA should not have placed her solied glove into the medicated cream container. RN-A also verified proper hand washing and dressing change procedures had not been followed during RP's dressing thange. Wound care and infection control policies were requested, but were not provided.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	COMPLET
giuze and dressing fell onto the floor from dressing container which LPN-A picked up with gloved hands and placed on a chair. LPN-A did not remove her gloves and wash her hands after touching the floor. LPN-A brought in 4 pages of treatment sheets which were placed on top of a contaminated book the resident had been reading prior to the observation. LPN-A removed packing from inside the wound, disposed of the solled dressing, and then proceeded to finger through wearing contaminated gloves to obtain clean dressing supplies from the container. Registered nurse (RN)-A then entered room and observed the ending of the bed bath and dressing change. RN-A advised NA's to wash hands and don new gloves since they had performed pericare for the resident. In addition, RN-A informed the staff they would need to discard the medicated cream, as NA-D had used her gloves dhan to remove cream from the jar. RN-A then asked LPN-A if she had changed gloves adhre removing solled packing from the wound. LPN-A verified she had not change her gloves and was advised to change her gloves and was her hands. Following the observation, RN-A verified the treatment sheets should not have been placed on R0's personal items in the room and the NA should not have placed her solled glove into the medicated cream container. RN-A also verified proper hand washing and dressing change procedures had not been followed during R9's dressing change. Wound care and infection control policies were requested, but were not provided.	21390	Continued From page	e 20	21390			
on 08/02/16 before the lunch meal and licensed		gauze and dressing f dressing container wi gloved hands and pla not remove her glove touching the floor. LP treatment sheets whi contaminated book the prior to the observation from inside the wound dressing, and then prive wearing contaminated dressing supplies from nurse (RN)-A then end the ending of the bed RN-A advised NA's to gloves since they had resident. In addition, would need to discard NA-D had used her glove cream from the jar. R she had changed glove packing from the wound not changed her glove change her gloves and Following the observa- treatment sheets sho R9's personal items i should not have placed medicated cream cor proper hand washing procedures had not be dressing change. Wound care and infer requested, but were the R3 and R47 received	ell onto the floor from hich LPN-A picked up with aced on a chair. LPN-A did as and wash her hands after PN-A brought in 4 pages of ch were placed on top of a he resident had been reading on. LPN-A removed packing d, disposed of the soiled roceeded to finger through d gloves to obtain clean m the container. Registered thered room and observed I bath and dressing change. D wash hands and don new d performed pericare for the RN-A informed the staff they d the medicated cream, as ploved hand to remove 2N-A then asked LPN-A if ves after removing soiled und. LPN-A verified she had es, and was advised to nd wash her hands. ation, RN-A verified the uld not have been placed on n the room and the NA ed her soiled glove into the ntainer. RN-A also verified and dressing change been followed during R9's ction control policies were not provided.				

STATE FORM

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		00480	B. WING		08	C 3/04/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21390	Continued From page	e 21	21390			
	practical nurse (LPN) glucose monitor for b properly cleaning bet					
	going to check two reperformed on resider diabetes). LPN-B ret monitor and supplies and went into R3's ro the blood glucose tes containing the blood supplies and indicate resident. LPN-B ther There was no cleanin monitor, LPN-B comp for R47 left the room back on a shelf in the	rieved a blood glucose kept in a small plastic tote om. At the completion of st, LPN-B took the tote				
	usually have their ow share the facility's me LPN-B verified the blo cleaned after use in t should have been cle antibacterial, antiviral	verified the residents do not in glucometer and need to eter to complete the tests. bod glucose monitor was not between residents and eansed with the provided I wipes. LPN-B indicated rgot to cleanse the monitor.				
	verified the blood glu cleansed with a disin manufacturing guidel	n., the director of nursing cose monitor should be fectant wipe per ines in between residents d just been some teaching				
	glucose monitoring e	policy and procedure for quipment, dated 7/2015 was t 8:45 a.m. by the director of				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
						С
		00480	B. WING		30	8/04/2016
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From page	e 22	21390			
	glucometer with the w resident. The center effective process for glucometer's after ea Procedure Bullet Cle as follows; "1. Use t all external parts of th a. A specific amount required for first clean test 2. Remove glove 4. Don clean gloves, and fresh paper towe external parts of the cleaning 7. Place the paper towel A. allow the contact time require glucose test 8. emove	decontaminating ch use on each resident " aning the Glucometer reads the disinfectant wipe to clean ne glucometer with gloves on of wet contact time is not ning after the blood glucose es 3. Perform hand hygiene 5. Obtain a second wipe el 6. Use the wipe to clean all glucometer for the second glucometer on the fresh v the meter to remain wet for irred by manufacturer's pre completing another e gloves 9. Perform hand ucometer in appropriate				
	The director of nursin review and revise po to infection control ar The director of nursin a system to educate monitoring system to	IOD OF CORRECTION: ing (DON) or designee could licies and procedures related ind tuberculosis screening. ing or designee could develop staff and develop a ensure staff are delivering icies and procedures.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21426	MN St. Statute 144A Prevention And Cont	.04 Subd. 3 Tuberculosis rol	21426			
	(a) A nursing home maintain a comprehe	provider must establish and				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY IPLETED	
			A. BUILDING:				
		00480	B. WING		08	C 08/04/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21426	infection control prog current tuberculosis i issued by the United Control and Prevention Tuberculosis Eliminan Morbidity and Mortali This program must in infection control plan unpaid employees, cor residents, and volunt Health shall provide to regarding implementa	ram according to the most nfection control guidelines States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR). Include a tuberculosis that covers all paid and ontractors, students, eers. The Department of rechnical assistance ation of the guidelines.	21426				
	by: Based on interview a facility failed to docur tuberculosis (TB) skin for 3 of 5 residents (F for TB screening. The medical evaluation w residents (R23) with facility failed to ensur Screening Tool for Nu Care Home Resident Findings include:	at is not met as evidenced nd document review, the ment complete results of the n test (TST) that was given R92, R93, R124) reviewed e facility failed to ensure a as completed for 1 of 5 chest x-ray results. The re completion of Baseline TB ursing Home and Boarding is for 1 of 5 residents (R23).					
	R93's annual Minimu 6/30/16. R93's immu	the facility on 6/26/15, per m Data Set (MDS) dated nization record dated 3's 2nd step TST did not					

TATEMENT	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		с	
		00480	B. WING		08	3/04/2016
IAME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
ALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	e 24	21426			
	have a negative read	ing.				
	R23's quarterly MDS immunization record R23's chest x-ray did	the facility on 2/28/14, per dated 5/31/16. R23's dated 6/20/13, revealed not include a physician ndicated R23 received INH 20 with no exact date.				
	R124's quarterly MDS	o the facility on 1/21/16, per S dated 5/20/16. R124's dated 1/13/16, revealed a 2nd step TST.				
	R92's quarterly MDS immunization record	the facility on 2/29/16, per dated 5/12/16. R92's dated 3/16/15, revealed R92 or 2nd step TST reading.				
		terim IDON who was of TB information. The IDON n was the facility follow their				
	dated July 2015 direct administer the two-ste Derivative (PPD) Tes required by State Reg unless they have doo previous positive skin millimeters (mm) of in x-ray and a medication	ep Mantoux Purified Protein t to all new residents as gulations on admission sumented evidence of a				
	SUGGESTED METH	OD OF CORRECTION: The				

STATEMEN	a Department of Healt T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C	
		00480	B. WING			/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETE DATE
21426	Continued From page	e 25	21426			
	-	on resident and employee ng and perform audits to				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
21510	MN Rule 4658.1200 SpecializedRehabilita	Subp. 2 A.B. ative Services; Provision	21510			
	rehabilitative services resident's compreher nursing home must:	nsive plan of care, the ired services; or obtain the m an outside source				
	by: Based on document i	-				
	Findings include:					
	admitted on 3/24/16, Down syndrome and Report Level II Pread dated 3/28/16, listed diagnosis for this resi Treatment section of does require active tr assures that all active	iew showed that R99 was with diagnoses including dementia. An Evaluative lmission Screening form, "mental retardation" as a ident. The Need For Active this form read, "This person eatment. The local agency e treatment needs have been on's individual service plan				

TATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			С
		00480	B. WING		08	8/04/2016
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
ALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21510	Continued From page	e 26	21510			
	nursing facility." The current plan of care, dated 3/25/16, did not contain active treatment interventions for R99.					
	worker (SS)-A was as active treatment for R could not locate docu treatment for R99. The facility's procedure for for residents with a Lo Screening that determ needed. SS-A stated not have a procedure treatment, and this wo needed to develop go	he surveyor asked for the r providing active treatment evel II Preadmission nined active treatment was I that the facility currently did to provide the active as something the facility bing forward. acility's MI/MR Preadmission ed July 2015, read, d services, if Level II				
	The director of nursin review and revise pol to Level II Preadmiss of active treatment. T designee could devel and develop a monito are delivering care ac procedures.	OD OF CORRECTION: Ig (DON) or designee could icies and procedures related ion Screening and provision The director of nursing or op a system to educate staff oring system to ensure staff ccording to policies and				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
21620	MN Rule 4658.1345 I	Labeling of Drugs	21620			
	Drugs used in the nu	rsing home must be labeled				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		с	
		00480	B. WING		30	5/04/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
PRÉFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLET DATE
21620	Continued From page	e 27	21620			
	in accordance with part 6800.6300.					
	This MN Requirement is not met as evidenced					
	by: Based on observation	n, interview and document				
	review, the facility fail	ed to ensure medications				
		in one of two med carts on storage, involving 3				
		nd R74) of 33 residents.				
	Findings include:					
		uring medication storage led to date medications such alers when opened.				
		0.5% eye drops (a and Olopatadine Hcl 0.1 % c conjunctivitis) was open				
	and was undated.	imolol 22.3-6.8/1 drops				
	(increase eye pressur undated.	re) was open and was				
	R74's Proair HFA (re was open and was ur	scue inhaler for asthma) ndated.				
	On 8/2/16 3:30 p.m. v	with Licensed Practical				
	Nurse (LPN)-C verifie	ed the medications were still				
		use and were opened and ditems would be removed				
		n. the director of nursing edications should be dated				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SU COMPLET	
			A. BUILDING:			С
		00480	B. WING		08	3/04/2016
AME OF PI	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE		
ALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21620	Continued From page	e 28	21620			
	when opened and verified she would follow up to see that the medications had been removed and reordered.					
	medications, biologic indicated under bulle or biological package follow manufacturer/s respect to expiration medications. Facility opened on the medic	" Storage and Expiration of als syringes and needles " t 5. " Once any medication is opened, facility should supplier guidelines with dates for opened staff should record the date ration container when the ortened expiration date once				
	The director of nursin review and revise pol to dating of opened n nursing or designee of educate staff and dev ensure staff are deliv policies and procedur	OD OF CORRECTION: ing (DON) or designee could licies and procedures related inedications. The director of could develop a system to velop a monitoring system to ering care according to res. CORRECTION: Twenty-one				
21695	MN Rule 4658.1415 Housekeeping, Opera	•	21695			
	provide housekeeping necessary to maintain comfortable interior, i	bing. A nursing home must g and maintenance services n a clean, orderly, and ncluding walls, floors, tures, equipment, lighting,				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00480	B. WING	30	C 3/04/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From page	e 29	21695			
	 Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a functional and comfortable environment for 9 of 35 residents (R150, R4, R66, R89, R23, R9, R149, R107, R26) reviewed for environmental concerns. Findings include: On 8/3/16, at 1:00 p.m. during the environmental tour with the maintenance supervisor (MS), manager housekeeping (MH), manager (M), and district manager (DM), the following concerns were observed. R150's bed side grab bars had un-cleanable gray foam wrapped and taped around the bars. During tour, MS stated the foam was on the rails for residents who bump their heads. MS stated if the foam got damaged, maintenance replaced it. M stated it was an un-cleanable surface and if damaged they would replace it. MS indicated it would be an infection control concern if it was in an infection control room. 					
	with a large worn are directly in front of the permanent stain. MS be replaced in about R66's room window a brown knob sticking of MS stated it was an of indicated the piece tu position. R66 had indicated did always clean and sor an odor. MH stated the daily. M stated rooms	n with R63 was observed a in the middle of the floor, toilet. DM stated it was a indicated it was on the list to one week. air conditioner had a large butward above the controls. older air conditioner and urned to change the air flow d not think the room was netimes the bathroom had he bathrooms were cleaned is were deep cleaned once a the toilet had not been				

STATE FORM

STATEMEN	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		С	
		00480	B. WING		08	B/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From page	e 30	21695			
	R89 had indicated the buildinghad an odor and there was an odor in the room. R89's bedside chair had a large stain in the seat cushion. MH stated there was a new stain on the room divider curtain. DM stated he thought the unattended plants on the window sill could be the cause of the smell. M stated the room had stagnant air and it would help if the air conditioner was turned on. M confirmed the chair had a stain and stated it would be cleaned that night. R23 had indicated staff did not clean the bathroom daily. MH stated the bathrooms should be cleaned daily. R9 had indicated being too hot and had two fans blowing in her direction. The room air conditioner was set on high fan instead of high air conditioning. MS stated the air conditioner was on the wrong setting. It was set on high fan, not air conditioning and now the setting was changed so it was cool in the room.					
	night and the privacy conditioning and the he would get a fan in:	room was always warm at curtain blocked off the air fan in the room. MS stated stalled on the wall in a 1 would follow up to ensure it				
	stated the grab bar w demonstrated how it	locked in place. The resident it. MS stated his expectation				
		el rack was observed to be e would remove the towel in that area.				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		С	
		00480	B. WING		08	8/04/2016
IAME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
GALTIER I	HEALTH CENTER					
			AUL, MN 55103	PROVIDER'S PLAN O		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
21695	Continued From page	9 31	21695			
	policy would be provid paperwork was comp nurse station and rep MS further stated mai provided. On 8/4/16, at 12:50 p on fourth floor unit of stated staff could writ maintenance/houseke checked first in the m Maintenance complet be done right away. V staff paged maintenan Undated facility 2nd fl indicated: "8:00 Begir (using the 5 and 7 step DEEP CLEAN ROOM 10:45 Continue clean the 5 and 7 Step Clea Continue cleaning res and 7 Step Cleaning cleaning resident room Cleaning Method)" LIST indicated: "19. C Clean and disinfect si down bathroom pull c disinfect shower stall/ housekeeper dated 1 housekeeper perform dust mopping and dat and sanitizing bathroo and commodes. They daily cleaning and sat furniture" Facility ho	eeping concerns which he orning on all units. ted those which needed to With immediate concerns, nce. loor housekeeper sheet in cleaning resident rooms ep cleaning method), 10:15 A (from posted schedule), ing resident rooms (Using aning Method), 11:30 sident rooms (Using the 5 Method), 1:00 Continue ms (Using the 5 and 7 Step DEEP CLEAN CHECKOFF Clean and disinfect toilet. 20. ink. 21. Disinfect and wipe tords (NEW) 22. Clean and fub" Facility job title: light /1/2000 indicated: "the light is a variety of tasks, such as mp mopping floors, cleaning oms including sinks, tubs v are responsible for the nitizing of patient room busekeeping policy was				
	requested but none w					
	SUGGESTED METH	OD OF CORRECTION:				

STATEMENT	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:		с	
		00480	B. WING		08	8/04/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From page	e 32	21695			
	educate staff regardin clean, functional and DON or designee, co maintenance and hou periodic audits of are ensure a safe, clean, environment is maint	ng (DON) or designee, could ng the importance of a safe, homelike environment. The ould coordinate with usekeeping staff to conduct as residents frequent to functional and homelike ained to the extent possible. CORRECTION: Twenty-one				
21805	Residents of HC Fac Subd. 5. Courteous residents have the rig courtesy and respect	s treatment. Patients and	21805			
	by: Based on observation review, the facility fai manner which promo	nt is not met as evidenced n, interview, and document led to provide services in a ted dignity for two of two who reported they were not manner.				
	Findings include:					
	review, the facility fai manner which promo	n, interview, and document led to provide services in a ted dignity for two of two who reported they were not manner.				
	Findings include:					

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			С
	00480		B. WING	00	B/04/2016	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
GALTIER I	HEALTH CENTER					
			AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page	e 33	21805			
	R89 was assessed as moderate cognition related to dementia according to the 6/27/16 care area assessment (CAA) and required staff assistance with activities of daily living with redirection and reapproach.					
	expressed staff did n dignity. R89 further s prior, a staff member answered her call ligh do you want?" The re	on 8/1/16, at 5:58 p.m. R89 ot treat her with respect and tated that about one week on the evening shift had ht by stating abruptly, "What esident said she had reported t staff. R89 stated the way to her made her feel				
	a.m. licensed practica inform R89 of the pro- dressing change, fail additional treatments to explain the steps of	of cares on 8/3/16, at 10:45 al nurse (LPN)-A failed to ocess required to complete a ed to talk with R89 during being completed and failed of the treatment. R89 was ed to acknowledge that R89 at the cares provided.				
	to the minimum data	cognitively intact according set (MDS) admission I total assistance with g.				
	LPN-A handed R9 m your meds." R9 resp just vitamins. I don't r medications in the tra you do that for?" LPN pick up the trash bag	n on 8/3/16, at 9:05 a.m. edications stating, "Here are onded by stating, "These are need them" and threw the ash. LPN-A stated, "What did I-A was then observed to and leave the room. There of what the medications were,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00480	B. WING		08	C 8/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE		
GALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI DATE
21805	Continued From page	e 34	21805			
	when R9 asked LPN- my dressing?" LPN-A and walk down the ha R9. R9 called out lou change my dressing? return to R9's room, I hallway that she wou obtained the supplies R9 stated, "That mad unimportant." During an observatio LPN-A returned to R9 dressing change. Dur informed LPN-A, "Thi did not respond and of dressing change. R9 stated to the resident resident held LPN-A's wound care. Review of R9's recom Progress Notes, date pain assessment. Re in pain medsReside and explain cares ste anxiety and/or pain d When interviewed on registered nurse (RN expectations were for dignity and respect p	ring the dressing change, R9 is hurts you know." LPN-A continued to perform the then stated, "Ouch!" LPN-A t, "I haven't touched it." The s arm from performing d, a document titled, ed, 8/3/16, read, "Completed esident recently had increase ent to participate in cares ep by step to decrease luring cares." 18/4/16, at 9:50 a.m.)-B reported the r staff to follow the facility's olicy. Staff were to introduce				
	resident. RN-B verified during cares and treat	ne resident regarding tments, and to engage the ed the facility expectation atments would be to inform u are doing during each step				

STATEMEN	a Department of Healt FOF DEFICIENCIES DF CORRECTION					E SURVEY PLETED
			B. WING		С	
		00480			08/04/2016	
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BALTIER	HEALTH CENTER		TIER AVENUE AUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pag	e 35	21805			
	Resident Rights, incl Rights which read, "I and Participation. Yo care from the facility environment that pro enhances dignity and your individuality." SUGGESTED METH The director of nursin review and revise po to ensuring that resid courtesy and respect designee could deve and develop a monity are delivering care an procedures.	the dated 7/15 policy titled, uded the Resident Bill of Dignity/Self Determination u have the right to receive in a manner and in an motes, maintains, or d respect if full recognition of AOD OF CORRECTION: ng (DON) or designee could licies and procedures related tents are treated with the director of nursing or lop a system to educate staff oring system to ensure staff ccording to policies and CORRECTION: Twenty-one				