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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: CSZD
Facility ID: 00480

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **09/19/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

12. Total Facility Beds **107** (L18)
13. Total Certified Beds **107** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	107			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 09/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS
Posted 10/31/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/07/2016
(L33)

DETERMINATION APPROVAL

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.

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.

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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245340		9/19/2016

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).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 09/13/2016	ID Prefix F0258 Reg. # 483.15(h)(7) LSC	Correction Completed 09/13/2016	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 09/13/2016
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 09/13/2016	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 09/13/2016	ID Prefix F0406 Reg. # 483.45(a) LSC	Correction Completed 09/13/2016
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 09/13/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 09/13/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction 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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 10/25/2016	SIGNATURE OF SURVEYOR 16022	DATE 09/19/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245340	A. Building 01 - MAIN BUILDING B. Wing	9/21/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 09/13/2016	ID Prefix Reg. # NFPA 101 LSC K0066	Correction 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 Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 10/25/2016	SIGNATURE OF SURVEYOR 19251	DATE 09/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
245340 (Y1)	(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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 09/13/2016	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction 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 Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 10/25/2016	SIGNATURE OF SURVEYOR 16022	DATE 09/19/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
8/4/2016	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: CSZD
Facility ID: 00480

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **08/04/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **107** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	107			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE NE II 08/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/01/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 09/06/2016 Co.

DETERMINATION APPROVAL

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, 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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

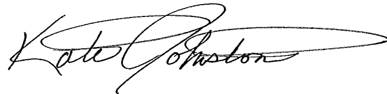
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. 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,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING ______ B. WING ______	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted August 1, 2, 3, 4, 2016, and complaint investigations were also completed at the time of the standard survey. An investigation of complaints #H5340040 and #H5340041 were completed. The complaints were substantiated and deficiencies were cited at F314 and F315. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in a manner which promoted dignity for two of two	F 241	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This	9/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 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.

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F 241	Continued From page 1 residents (R89, R9) who reported they were not treated in a dignified manner. Findings include: 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. During an interview on 8/1/16, at 5:58 p.m. R89 expressed staff did not treat her with respect and dignity. R89 further stated that about one week prior, a staff member on the evening shift had answered her call light by stating abruptly, "What do you want?" The resident said she had reported the incident to a night staff. R89 stated the way the staff had spoken to her made her feel "unimportant." During observations of cares on 8/3/16, at 10:45 a.m. licensed practical nurse (LPN)-A failed to inform R89 of the process required to complete a dressing change, failed to talk with R89 during additional treatments being completed and failed to explain the steps of the treatment. R89 was upset and LPN-A failed to acknowledge that R89 was crying throughout the cares provided. R9 was assessed as cognitively intact according to the minimum data set (MDS) admission 5/26/16, and required total assistance with activities of daily living. 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	F 241	submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report." R9 and R89 have been assessed related to the treatment with respect and dignity and no further findings. Staff identified will have 1:1 education completed on 8/3/16. Residents @ Galtier Health Center will be treated with dignity and respect. The staff were provided education on Dignity and Respect on 8/3/16. The staff are being re-educated on treating the residents with dignity and respect. Caring Partners will interview residents regarding treatment of resident's with dignity and respect weekly x 8 weeks, if audits are satisfactory, will decrease audits to monthly x 3 months, if satisfactory will complete audits quarterly. Results of the audits will be reported monthly at the QAPI meeting. The Director of Social Service will be responsible to monitor compliance.	

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F 241	Continued From page 2	F 241		

medications in the trash. LPN-A stated, "What did you do that for?" LPN-A was then observed to pick up the trash bag and leave the room. There was no explanation of what the medications were, what they were for or the importance of the medications. LPN-A turned to leave the room when R9 asked LPN-A, "Are you going to change my dressing?" LPN-A continued to exit the room and walk down the hall without acknowledging R9. R9 called out louder, "Are you going to change my dressing?" LPN-A did not stop and return to R9's room, but called back from the hallway that she would come back after she obtained the supplies. Following the interaction R9 stated, "That made me feel ignored and unimportant."

During an observation on 8/3/16, at 9:15 a.m. LPN-A returned to R9's room to perform a dressing change. During the dressing change, R9 informed LPN-A, "This hurts you know." LPN-A did not respond and continued to perform the dressing change. R9 then stated, "Ouch!" LPN-A stated to the resident, "I haven't touched it." The resident held LPN-A's arm from performing wound care.

Review of R9's record, a document titled, Progress Notes, dated, 8/3/16, read, "Completed pain assessment. Resident recently had increase in pain meds...Resident to participate in cares and explain cares step by step to decrease anxiety and/or pain during cares."

When interviewed on 8/4/16, at 9:50 a.m. registered nurse (RN)-B reported the expectations were for staff to follow the facility's dignity and respect policy. Staff were to introduce themselves, inform the resident regarding

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F 241	Continued From page 3 medications and treatments, and to engage the resident. RN-B verified the facility expectation during cares and treatments would be to inform the resident what you are doing during each step of the procedure. Document review of the dated 7/15 policy titled, Resident Rights, included the Resident Bill of Rights which read, "Dignity/Self Determination and Participation. You have the right to receive care from the facility in a manner and in an environment that promotes, maintains, or enhances dignity and respect if full recognition of your individuality."	F 241		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This 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 4 of 35 residents (R29, R89, R107, R66) 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 discussed. R29 had stated it was noisy all day and at night when going to bed. R29 indicated another resident in the room next door screamed all night	F 258	Resident's R29, R89, R107 & R66 were offered ear plugs. Care plans and nursing assistant assignment sheets will be updated accordingly. Completion date 8/26/16. Galtier Health Center's goal is to maintain a functional and comfortable environment. The staff on duty were educated on noise level concerns on 8/3/16. The staff are being reeducated on comfortable sound levels. Ear plugs will	9/13/16

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F 258	Continued From page 4 and staff yelled in the hallway. MS stated would need to address concern with unit nurse manager and interim director of nursing (IDON). R89 had stated the nurses yelled in the hallway, did not speak normally, just screamed and was unable to sleep due to their yelling. M stated would relay to the IDON that sounds echo. R107 had stated staff should be quiet at night. Staff and residents were too noisy, talking and hollering. M stated the noise could echo because there was no carpeting. 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 258	be available to the residents at the nurses station. Completion date 8/25/16. Caring Partners will interview residents about sound levels weekly x 8 weeks, if audits are satisfactory will decrease audits to monthly x 3 months, if satisfactory will complete audits quarterly. Results of audits will be reported monthly at the QAPI meeting. The Executive Director will be responsible to monitor compliance.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		9/13/16

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F 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced 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: Admission record review showed that R99 was admitted on 3/24/16, with diagnoses including Down syndrome and dementia. An Evaluative Report Level II Preadmission Screening form, dated 3/28/16, listed "mental retardation" as a diagnosis for this resident. The Need For Active Treatment section of this form read, "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." The current plan of care, dated 3/25/16, did not contain active treatment interventions for R99. During interview on 8/4/16, at 9:45 a.m. social worker (SS)-A was asked for documentation of	F 279	R99's Level II Preadmission Screening has been redone. Completed 8/24/16. R99's care plan has been updated with interventions to address any special needs related to qualifying Level II diagnosis. Completed 8/24/16. Resident's medical reocrds were audited for Preadmission screening and the need for active treatment. Completed 8/19/16. Care plans have been updated as needed. Social worker will audit new residents on an ongoing basis for indications that active treatment is required during Comprehensive Care Plan Review. Audit results will be reported in the QAPI monthly meeting x 3 months or until deemed necessary to monitor compliance. The Director of Social Services will be	

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F 279	Continued From page 6 active treatment for R99. SS-A stated that she could not locate documentation of active treatment for R99. The surveyor asked for the facility's procedure for providing active treatment for residents with a Level II Preadmission Screening that determined active treatment was needed. SS-A stated that the facility currently did not have a procedure to provide the active treatment, and this was something the facilty needed to develop going forward.	F 279	responsible to monitor compliance.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R9) who was identified at risk for pressure ulcer development. Findings include: R9 was assessed as cognitively intact according to the minimum data set (MDS) admission 5/26/16, and required total assistance with activities of daily living.	F 314	Resident R9's skin risk and need for repositioning will be reevaluated and care plan updated as needed. NA responsible for R9 on 8/3/16 received a disciplinary action on 8/16/16. Nursing assistant assignment sheets, care plans and tissue tolerance sheets (as Indicated) have been audited for residents who require assistance with positioning for appropriate frequency of repositioning.	9/13/16

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F 314	Continued From page 7	F 314		

During an observation on 8/1/16, at 5:58 p.m. R9 was lying on her back in bed. When interviewed, R9 stated that every two hour repositioning was to be conducted and had only been repositioned twice that day.

During continuous observation on 8/3/16, from 7:00 a.m. until 10:30 a.m. three hours and thirty minutes R9 remained lying on back without an offer to change position.

On 8/3/16, at 7:45 a.m. nursing assistant (NA)-B was observed to enter the room to provide care for R9's roommate. At 8:04 a.m., NA-B verified no care had yet been provided for R9 that morning. R9 continued lying on back in bed. At 8:27 a.m., the social service's assistant (SSA)-B entered R9's room for the breakfast order. R9's breakfast tray was delivered at 8:43 a.m. At 9:54 a.m. R9 informed the surveyor that no postioning had taken place since 5:00 a.m. or so, since the night shift staff had done it. R9 stated no day shift staff had offered repositioning. When R9 was administered morning medications, LPN-A told the surveyor that she had not assisted R9 with any cares that day. At 10:08 a.m. R9 again said the last time being repositioned was at 5:00 a.m. or so, and "feels stiff." The surveyor encouraged the resident to use the call light to ask for help. The director of nursing (DON) responded to R9's call light and R9 informed the DON that repositionig was needed. At 10:24 a.m., NA-B and NA-D entered the resident's room to provide morning cares.

R9's 6/2/16, Minimum Data Set (MDS) indicated the resident required extensive to total assistance with cares including repositioning. The MDS further indicated R9 had moderate cognitive

Nursing staff have been reeducated on timely repositioning.

Residents are reviewed for skin risk and repositioning upon admission, quarterly and with significant change with care plans being updated as needed through the facility's comprehensive care plan review meeting.

Audits for repositioning will be completed 5x/week x 4 weeks, if satisfactory will decrease to 3x/week x 2 weeks, if satisfactory will decrease to weekly x 4 weeks and then quarterly until QAPI team deems unnecessary.

The Director of Nursing will be responsible for monitoring compliance.

Audit results will be reported at the monthly QAPI meeting.

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F 314	Continued From page 8 impairment but did not reject cares. A pressure ulcer risk was noted, with unhealed pressure ulcers at Stage 1 or greater. A nurse practitioner's (NP) note dated 7/20/16, revealed the resident had pressure ulcer risk factors including morbid obesity, diabetes, multiple sclerosis, and malnutrition. In addition, the NP's notes indicated the resident had a surgical flap for pressure ulcers 3/19/16, with subsequent graft failure. The medical record indicated R9 had been hospitalized 4/10/16, and had subsequently been re-admitted to the facility on 5/26/16. Document review of a physician's order dated 7/21/16, directed staff to provide repositioning for R9 to keep back and buttock open to air at least three times daily. 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. Document review of the policy dated 7/15, titled, Turning and Repositioning Program, directed staff to turn and reposition residents every 1-2 hours when in bed. When interviewed on 8/4/16 at 10:24 a.m., registered nurse (RN)-B verified the facility expectation was for R9 to be repositioned every two hours.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		9/13/16

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F 315	Continued From page 9 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate incontinence care for 1 of 1 resident (R89) reviewed for incontinence care. Findings include: 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 (ADL's) with redirection and reapproach for refusals. During an observation on 8/2/16, at 10:29 a.m. and again 8/3/16, at 8:40 a.m. there were strong urine odors permeating on R89's person and room area. When interviewed on 8/3/16, at 8:45 a.m. licensed practical nurse (LPN)-A reported [R89] independently toileted self. During an interview on 8/3/16, at 8:59 a.m. R89 complained the staff did not provide assistance and had to do everything per self. R89 said it did	F 315	R89 will have a new 3 day voiding diary and bladder assessment completed. Care plan will be updated to reflect current toileting needs. Residents requiring assistance with incontinent needs will have bladder assessments, care plans and care delivery guides reviewed and revised as necessary. Nursing staff to be reeducated on toileting and providing incontinence care. Resident status of toileting needs to include, but not limited to incontinent care will be reviewed upon admission, quarterly and with any significant change in status through the facility's comprehensive care plan review meeting. Audits will be completed on toileting and incontinence care 5x/week x 4 weeks, if satisfactory will decrease to 3x/week x 2 weeks, if satisfactory will decrease to	

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F 315	Continued From page 10	F 315		

no good to turn on the call light for help and boldly stated, "they won't help me."

During an observation of a wound dressing change by LPN-A on 8/3/16, at 9:36 a.m. R89 reported the need to urinate. LPN-A asked, "Do you need any help?" to which the resident replied, "I do." R89's brief was soaked with a large 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

weekly x 4 weeks and then quarterly until QAPI team deems unnecessary.

Audit results will be reported at the monthly QAPI meeting.

The Director of Nursing will be responsible for monitoring for compliance.

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F 315	Continued From page 11 changing the brief. The facility's 7/15, Management of Urinary Incontinence policy directed staff to utilize the Alteration in Urinary Continence Care Plan to identify urinary problems, goals, and interventions appropriate for the resident.	F 315		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not provide required active treatment for 1 of 1 resident (R99) reviewed for preadmission screening. Findings include: Admission record review showed that R99 was admitted on 3/24/16, with diagnoses including Down syndrome and dementia. An Evaluative Report Level II Preadmission Screening form, dated 3/28/16, listed "mental retardation" as a diagnosis for this resident. The Need For Active Treatment section of this form read, "This person	F 406	R99's Level II Preadmission Screening has been redone. Completed 8/24/16. R99's care plan has been updated with interventions to address any special needs related to qualifying Level II diagnosis. Completed 8/24/16. Resident's medical reocrds were audited for Preadmission screening and the need for active treatment. Completed 8/19/16. Care plans have been updated as needed.	9/13/16

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F 406	Continued From page 12 does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." The current plan of care, dated 3/25/16, did not contain active treatment interventions for R99. During interview on 8/4/16, at 9:45 a.m. social worker (SS)-A was asked for documentation of active treatment for R99. SS-A stated that she could not locate documentation of active treatment for R99. The surveyor asked for the facility's procedure for providing active treatment for residents with a Level II Preadmission Screening that determined active treatment was needed. SS-A stated that the facility currently did not have a procedure to provide the active treatment, and this was something the facilty needed to develop going forward. Section 3.5.1 of the facility's MI/MR Preadmission Screening policy, dated July 2015, read, "...Provide specialized services, if Level II indicates that it is required."	F 406	Social worker will audit new residents on an ongoing basis for indications that active treatment is required during Comprehensive Care Plan Review. Audit results will be reported in the QAPI monthly meeting x 3 months or until deemed necessary to monitor compliance. The Director of Social Services will be responsible to monitor compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		9/13/16

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F 431	Continued From page 13 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored properly in one of two med carts reviewed for medication storage, involving 3 residents (R6, R56, and R74) of 33 residents. Findings include: During observation during medication storage review, the facility failed to date medications such as eye drops and inhalers when opened. During the medication storage tour on 8/2/16 at	F 431	Resident R6 Combigan and Oloptadine eye drops were dated with the date opened dates equal to the day of the medication refill date. Resident R56 Dorzolamide-Timolol eye drops were removed from the medication cart and reordered. Resident R74 Proair was removed from the cart. Medication storage procedures will be	

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F 431	Continued From page 14 3:15 p.m., with licensed practical nurse (LPN)-C on the fourth floor unit medication cart, observations included the following: R6's combigan 0.2%-0.5% eye drops (a glaucoma eye drop) and Olopatadine Hcl 0.1 % eye drops (for allergic conjunctivitis) was open and was undated. R56's Dorzolamide-Timolol 22.3-6.8/1 drops (increase eye pressure) was open and was undated. R74's Proair HFA (rescue inhaler for asthma) was open and was undated. On 8/2/16 3:30 p.m. with Licensed Practical Nurse (LPN)-C verified the medications were still 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 431	reviewed with the licensed nurses and TMA's. Medication carts will be audited for proper dates open documentation 2x/week x 4 weeks, if satisfactory will decrease to weekly x 4 weeks, if satisfactory will decrease to monthly x 3 months and if results are satisfactory will decrease to quarterly. Audit results will be reported at the monthly QAPI meeting. The Director of Nursing is reponsible to monitor compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		9/13/16

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F 441	Continued From page 15	F 441		

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to minimize the risk for the spread of infection during wound care for 2 of 2 residents (R89, R9) observed for wound care, and to implement procedures to prevent the spread of infection during blood glucose monitoring for 2 of 2 residents (R3, R47) observed who required blood glucose monitoring. Findings include: During an observation on 8/3/16, at 8:59 a.m. R89's wound dressing from the right shin had fallen down to the ankle area. During interview R89 informed the surveyor of "going downstairs to smoke" and explained not asking for help, as the staff "won't help me." The surveyor suggested R89 use the call light to summon assistance. Licensed practical nurse LPN-A responded and said she would change the wound dressing. LPN-A was carrying a page from R89's medication sheet, which was placed on the contaminated bedside table next to the dressing container and under the normal saline bottle used for cleansing the wound. LPN-A informed R89 she would go to get supplies to complete the dressing change and subsequently left the room. R89 stated that every other day the dressing change was completd per self, without staffs' assistance, because they did not care. At 9:15 a.m. LPN-A re-entered room with supplies and initiated the dressing change. R89 reported to LPN-A the staff were not performing the dressing changes, LPN-A indicated she would let staff know about the concern. LPN-A washed hands, donned gloves and put plastic under R89's foot	F 441	LPN A was immediately in serviced on proper infection control techniques during a dressing change. Nursing staff on duty were reeducated immediately on proper infection control technique during a dressing change on 8/3/16. The licensed nurses will be reeducated on infection control and dressing changes. The nursing staff will be reeducated on appropriate times to wash hands and change gloves. Audits will be conducted on clean dressing changes for proper infection control techniques 3x/week x 4 weeks, if satisfactory will decrease audits to weekly x 4 weeks, if satisfactory will decarese audits to monthly x 3 months. Education was initiated during the survey on the procedure for Glucose Monitoring Equipment 8/3/16. Licensed nurses and TMA's will be educated on cleaning procedure and frequency of cleaning blood glucose monitoring machines. Audits will be conducted on appropriate procedure and frequency of glucometer cleaning 3x/week x 4 weeks, if results are satisfactory will decrease audits to weekly x 4 weeks, if results are satisfactory will	

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F 441	Continued From page 17 on the bed. Normal saline was poured to facilitate removal of the partially attached Tegaderm dressing covering the wound. LPN-A used scissors from R89's personal supply container to cut off soiled dressing around the ankle. During cleaning of the wound R89 requested a hat which LPN-A handed it to R89, contaminating the same gloves. LPN-A then proceeded to apply powder to R89's wound. LPN-A used the same scissors used to cut off the soiled dressing to cut clean gauze to wrap the Tegaderm dressing. LPN-A removed gloves, washed hands, returned contaminated scissors into clean dressing container, and left the room to return the medication sheet to nurses' station. A physician progress note on 7/13/16, revealed R89's diagnoses included infection of right leg wound with history of basal cell carcinoma (skin cancer): "Culture per dermatology previously growing staph [bacterial infection]. Patient has completed a course of Bactrim [antibiotic]". Treatment record for 7/16/16, directed staff to change R89's dressing twice daily. Nursing notes showed multiple refusals of dressing change. Resident was instructed about importance of daily dressing changes. R89's Minimum Data Set on 6/21/16, indicated the resident had open lesions with applications of dressings. Additionally, the assessment noted the resident had moderately impaired cognition, but did not reject care. Registered nurse (RN)-B was interviewed on 8/4/16, at 10:24 a.m. and verified staff should have ensured R89's dressings were intact, and wound care should have been provided in a manner that promoted healing following the	F 441	decrease audits to monthly x 3 months and if results are satisfactory will decrease audits to quarterly. Audit results will be reported at the monthly QAPI meeting. The Director of Nursing is responsible to monitor compliance.	

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facility's infection control policies.

R9 did not receive infection control standards with cares and dressing change

During an observation on 8/3/16, at 10:24 a.m. R9 was assisted with repositioning and wound care by nursing assistant (NA)-D, NA-B and LPN-A. Neither NA washed hands prior to donning gloves and giving the resident a bed bath. At 10:35 a.m. LPN-A entered room to do dressing change. LPN-A donned gloves without hand washing/sanitizing and brought dressing 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 after removing soiled packing from the wound. LPN-A verified she had not changed her gloves, and was advised to change her gloves and wash her hands.

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Following the observation, RN-A verified the treatment sheets should not have been placed on R9's personal items in the room and the NA should not have placed her soiled 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.

R3 and R47 received blood glucose monitoring on 08/02/16 before the lunch meal and licensed practical nurse (LPN)-B used the same blood glucose monitor for both residents without properly cleaning between use.

On 8/2/16 at 10:42 a.m. LPN-B indicated was going to check two resident's blood sugars (test performed on resident with diagnoses of diabetes). LPN-B retrieved a blood glucose monitor and supplies kept in a small plastic tote and went into R3's room. At the completion of the blood glucose test, LPN-B took the tote containing the blood glucose monitor and supplies and indicated she needed to do another resident. LPN-B then went into R47's room. There was no cleaning of the blood glucose monitor, LPN-B completed the blood glucose test for R47 left the room and placed the supplies back on a shelf in the nursing station. LPN-B returned to the medication cart to review the medication record.

At 11:05 a.m. LPN-B verified the residents do not usually have their own glucometer and need to share the facility's meter to complete the tests.

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F 441	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 for the second cleaning 7. Place 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 441		
F 465	483.70(h)	F 465		9/13/16

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F 465 SS=E	Continued From page 21 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 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. R4's shared bathroom with R63 was observed with a large worn area in the middle of the floor, directly in front of the toilet. DM stated it was a permanent stain. MS indicated it was on the list to be replaced in about one week. R66's room window air conditioner had a large brown knob sticking outward above the controls. MS stated it was an older air conditioner and	F 465	The facility will maintain a safe, sanitary and comfortable environment. R150's un-cleanable grab bar covering was removed and covering with a cleanable surface will be applied upon arrival from distributor. Grab bars will be checked for uncleanable covering, if found will be removed and replaced upon arrival of supply. R4 and R63 bathroom tile was replaced on 8/10/16. The staff is being educated on ensuring grab bars on the beds are locked. R66's air conditioning unit was replaced 8/24/16. R9's air conditioner was placed on the air conditioning mode. Maintenance will in service on proper use of air conditioners. Laminated cards will be placed with instructions in each resident room. R149 had a fan placed in the room on 8/22/16.	

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F 465	Continued From page 22 indicated the piece turned to change the air flow position. R66 had indicated did not think the room was always clean and sometimes the bathroom had an odor. MH stated the bathrooms were cleaned daily. M stated rooms were deep cleaned once a month and identified the toilet had not been flushed which could cause the smell. R89 had indicated the building had 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. R149 had stated the room was always warm at night and the privacy curtain blocked off the air conditioning and the fan in the room. MS stated he would get a fan installed on the wall in a couple of days and M would follow up to ensure it was done.	F 465	R107's grab bar was locked in place. Towel bar in the bathroom was removed and area was repaired on 8/23/16. R107 has been educated on how to lock the grab bar in place on 8/24/16. Audits to ensure compliance in the aforementioned areas will be conducted 2x/week x 90 days. The Maintenance Director will be responsible for compliance. Audit results will be reported at the monthly QAPI meeting. R66 and R 23 bathrooms will be cleaned daily. Housekeeping will refinish the new floor in bathroom of R4 and R63. A weekly inspection of the replaced floors will be done x 3 months and if results are satisfactory will decrease to monthly x 3 months. R89's room divider curtain and chair were replaced immediately. All chairs and room divider curtains will be checked for stains and replaced as necessary. The halls will be cleaned daily. R89's room will be cleaned daily.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 23 R107's bed outside grab bar was loose. MS stated the grab bar was unlocked and demonstrated how it locked in place. The resident or staff could unlock it. MS stated his expectation was it was locked at all times. R26's bathroom towel rack was observed to be broken. MS stated he would remove the towel rack and put new tile in that area. On 8/3/16, at 2:03 p.m. MH stated housekeeping policy would be provided. MS stated work order paperwork was completed on each floor at the nurse station and reports given each morning. MS further stated maintenance policy would be provided. On 8/4/16, at 12:50 p.m. observation was made on fourth floor unit of work order requests. MS stated staff could write any maintenance/housekeeping concerns which he checked first in the morning on all units. Maintenance completed those which needed to be done right away. With immediate concerns, staff paged maintenance. Undated facility 2nd floor housekeeper sheet indicated: "8:00 Begin cleaning resident rooms (using the 5 and 7 step cleaning method), 10:15 DEEP CLEAN ROOM (from posted schedule), 10:45 Continue cleaning resident rooms (Using the 5 and 7 Step Cleaning Method), 11:30 Continue cleaning resident rooms (Using the 5 and 7 Step Cleaning Method), 1:00 Continue cleaning resident rooms (Using the 5 and 7 Step Cleaning Method)"... DEEP CLEAN CHECKOFF LIST indicated: "19. Clean and disinfect toilet. 20. Clean and disinfect sink. 21. Disinfect and wipe down bathroom pull cords (NEW) 22. Clean and disinfect shower stall/tub"... Facility job title: light	F 465	Inspections of the room and halls for odor will be conducted 5x/week x 1 month, upon satisfactory results, will decrease to weekly x 6 months. The Director of Housekeeping will be responsible for compliance. Results of audits/inspections will be reported at the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING ______ B. WING ______	C 08/04/2016

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F 465	Continued From page 24 housekeeper dated 1/1/2000 indicated: "the light housekeeper performs a variety of tasks, such as dust mopping and damp mopping floors, cleaning and sanitizing bathrooms including sinks, tubs and commodes. They are responsible for the daily cleaning and sanitizing of patient room furniture"... Facility housekeeping policy was requested but none was provided.	F 465		

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

F5340024

PRINTED: 08/31/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**08/03/2016**

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

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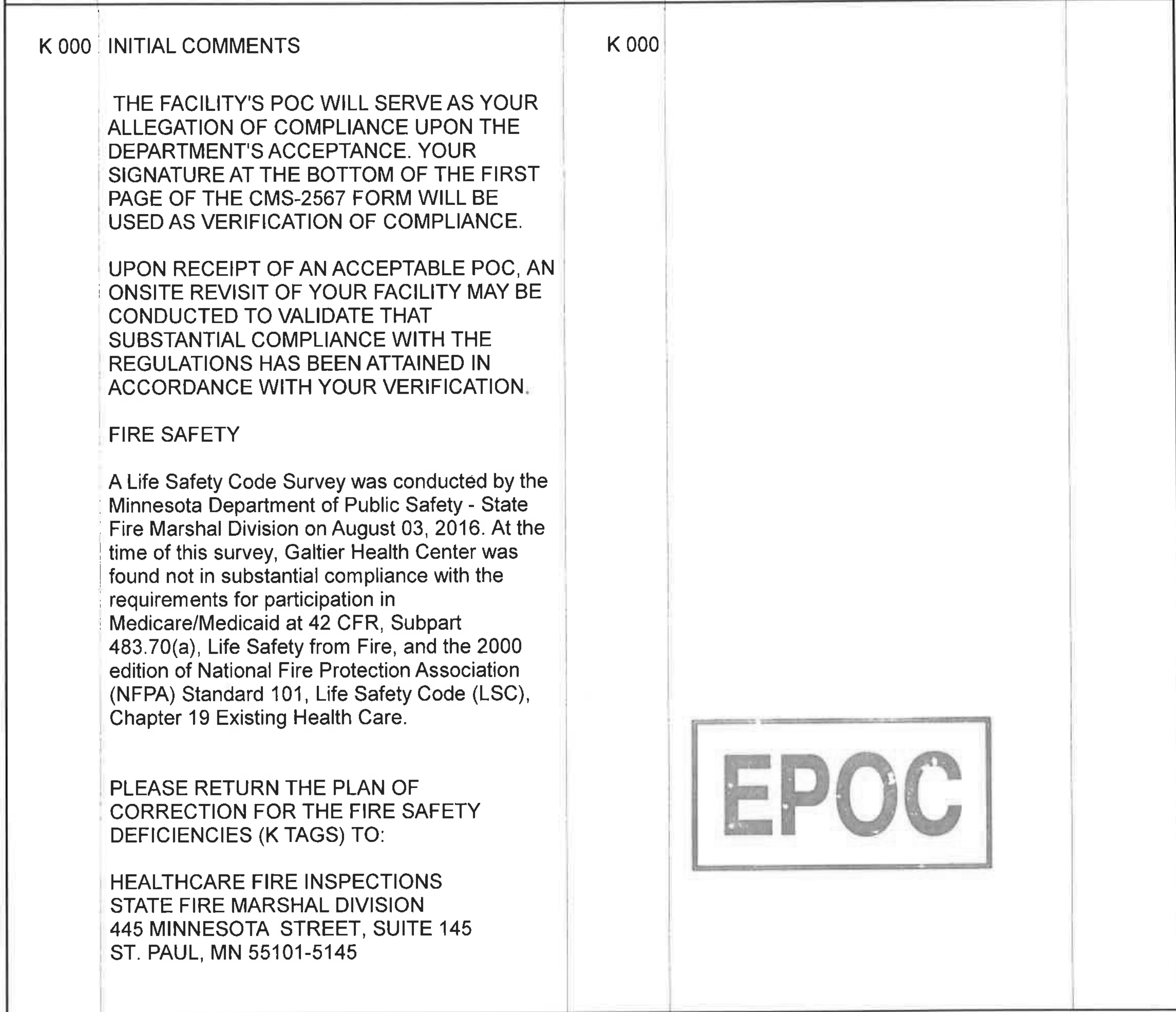
K 000	INITIAL COMMENTS	K 000		



INITIAL COMMENTS

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

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on August 03, 2016. At the time of this survey, Galtier Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

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

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically 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
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING 01 - MAIN BUILDING B. WING ________	08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency This 4-story building was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered. The facility has a capacity of 112 beds. At the time of the survey the census was 100. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was observed that one of several exterior exit sidewalks had a change in grade not in accordance with section 7.1., 19.2.1. Finding include: On facility tour between the hours of 12:30 PM	K 038	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."	9/13/16

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

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	245340	A. BUILDING 01 - MAIN BUILDING B. WING	08/03/2016

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K 038	Continued From page 2 and 4:00 PM on 8/03/2016, it was observed that the Northwest exterior exit sidewalk had a 1 1/2 inch change in grade leading to the public right-of way that could impose a tripping hazard. This deficient practice was verified by the Maintenance Supervisor at the time of inspection.	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.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, policy review and staff interview, the facility failed to follow policy for the designated resident smoking in accordance with NFPA LSC (00) Edition Section 19.7.4, and the facility's smoking policy. This deficient practice could affect 1- 5 residents.	K 066	Self contained cigarette ashtrays were placed in the smoking area and the staff smoking area. The self locking can for the cigarette butts was ordered and will ship 9/19/16 for the resident smoking area.	9/13/16

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K 066	Continued From page 3 Findings include: 1. On facility tour between 12:30 PM and 4:00 PM on 8/03/2016, it was observed that the outside designated employee smoking area had cigarette butts disposed of in the trash can with combustible material and the smoking area had no metal container with a self-closing cover device into which ashtrays can be emptied. This deficient practice was verified by the Maintenance Supervisor at the time of inspection.	K 066	The Director of Maintenance will monitor the smoking area daily Monday-Friday during preventative maintenance rounds.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota 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.

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.

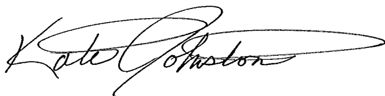
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00480	A. BUILDING: ______ B. WING ______	C 08/04/2016

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On August 1, 2016 through August 4, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 1, 2016 through August 4, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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2 000	Continued From page 1 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. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with	2 555		

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2 555	Continued From page 2	2 555		

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:

Admission record review showed that R99 was admitted on 3/24/16, with diagnoses including Down syndrome and dementia. An Evaluative Report Level II Preadmission Screening form, dated 3/28/16, listed "mental retardation" as a diagnosis for this resident. The Need For Active Treatment section of this form read, "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." The current plan of care, dated 3/25/16, did not contain active treatment interventions for R99.

During interview on 8/4/16, at 9:45 a.m. social worker (SS)-A was asked for documentation of active treatment for R99. SS-A stated that she could not locate documentation of active treatment for R99. The surveyor asked for the facility's procedure for providing active treatment for residents with a Level II Preadmission Screening that determined active treatment was

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2 555	Continued From page 3 needed. SS-A stated that the facility currently did not have a procedure to provide the active treatment, and this was something the facilty needed to develop going forward. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring care plan development for each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are developing a comprehensive written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be	2 840		

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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 skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate incontinence care for 1 of 1 resident (R89) reviewed for incontinence care. Findings include: 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 (ADL's) with redirection and reapproach for refusals.	2 840		

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	00480	A. BUILDING: ______ B. WING ______	C 08/04/2016

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2 840	Continued From page 5	2 840		

During an observation on 8/2/16, at 10:29 a.m. and again 8/3/16, at 8:40 a.m. there were strong urine odors permeating on R89's person and room area.

When interviewed on 8/3/16, at 8:45 a.m. licensed practical nurse (LPN)-A reported [R9] independently toileted 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."

During an observation of a wound dressing change by LPN-A on 8/3/16, at 9:36 a.m. R89 stated she needed to urinate. LPN-A asked, "Do you need any help?" to which the resident replied, "I do." R89's brief was soaked with a large amount of urine. A clean brief was provided, but LPN-A did not encourage the resident to use the toilet although she had reported she needed to urinate. In addition, pericare was not offered or provided, and the resident continued to smell of urine 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.

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2 840 Continued From page 6 2 840

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 changing the brief.

The facility's 7/15, Management of Urinary Incontinence policy directed staff to utilize the Alteration in Urinary Continence Care Plan to identify urinary problems, goals, and interventions appropriate for the resident.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring appropriate care and services related to incontinence. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing this care.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 900 MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 2 900

Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the

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2 900	Continued From page 7	2 900		

development of a nursing care plan which provides that:

A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and

B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R9) who was identified at risk for pressure ulcer development.

Findings include:

R9 was assessed as cognitively intact according to the minimum data set (MDS) admission 5/26/16, and required total assistance with activities of daily living.

During an observation on 8/1/16, at 5:58 p.m. R9 was lying on her back in bed. When interviewed, R9 stated that every two hour repositioning was to be conducted and had only been repositioned twice that day.

During continuous observation on 8/3/16, from 7:00 a.m. until 10:30 a.m. three hours and thirty minutes R9 remained lying on back without an offer to change position.

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2 900	Continued From page 8	2 900		

On 8/3/16, at 7:45 a.m. nursing assistant (NA)-B was observed to enter the room to provide care for R9's roommate. At 8:04 a.m., NA-B verified no care had yet been provided for R9 that morning. R9 continued lying on back in bed. At 8:27 a.m., the social service's assistant (SSA)-B entered R9's room for the breakfast order. R9's breakfast tray was delivered at 8:43 a.m. At 9:54 a.m. R9 informed the surveyor that no postioning had taken place since 5:00 a.m. or so, since the night shift staff had done it. R9 stated no day shift staff had offered repositioning. When R9 was administered morning medications, LPN-A told the surveyor that she had not assisted R9 with any cares that day. At 10:08 a.m. R9 again said the last time being repositioned was at 5:00 a.m. or so, and "feels stiff." The surveyor encouraged the resident to use the call light to ask for help. The director of nursing (DON) responded to R9's call light and R9 informed the DON that repositionig was needed. At 10:24 a.m., NA-B and NA-D entered the resident's room to provide morning cares.

R9's 6/2/16, Minimum Data Set (MDS) indicated the resident required extensive to total assistance with cares including repositioning. The MDS further indicated R9 had moderate cognitive impairment but did not reject cares. A pressure ulcer risk was noted, with unhealed pressure ulcers at Stage 1 or greater.

A nurse practitioner's (NP) note dated 7/20/16, revealed the resident had pressure ulcer risk factors including morbid obesity, diabetes, multiple sclerosis, and malnutrition. In addition, the NP's notes indicated the resident had a surgical flap for pressure ulcers 3/19/16, with subsequent graft failure. The medical record indicated R9 had been hospitalized 4/10/16, and

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2 900	Continued From page 9	2 900		

had subsequently been re-admitted to the facility on 5/26/16.

Document review of a physician's order dated 7/21/16, directed staff to provide repositioning for R9 to keep back and buttock open to air at least three times daily.

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.

Document review of the policy dated 7/15, titled, Turning and Repositioning Program, directed staff to turn and reposition residents every 1-2 hours when in bed.

When interviewed on 8/4/16 at 10:24 a.m., registered nurse (RN)-B verified the facility expectation was for R9 to be repositioned every two hours.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development and to promote healing of existing pressure ulcers.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning	2 905		

Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R9) who was identified at risk for pressure ulcer development.

Findings include:

R9 was assessed as cognitively intact according to the minimum data set (MDS) admission 5/26/16, and required total assistance with activities of daily living.

During an observation on 8/1/16, at 5:58 p.m. R9 was lying on her back in bed. When interviewed, R9 stated that every two hour repositioning was to be conducted and had only been repositioned twice that day.

During continuous observation on 8/3/16, from 7:00 a.m. until 10:30 a.m. three hours and thirty minutes R9 remained lying on back without an offer to change position.

On 8/3/16, at 7:45 a.m. nursing assistant (NA)-B was observed to enter the room to provide care

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2 905	Continued From page 11	2 905		

for R9's roommate. At 8:04 a.m., NA-B verified no care had yet been provided for R9 that morning. R9 continued lying on back in bed. At 8:27 a.m., the social service's assistant (SSA)-B entered R9's room for the breakfast order. R9's breakfast tray was delivered at 8:43 a.m. At 9:54 a.m. R9 informed the surveyor that no postioning had taken place since 5:00 a.m. or so, since the night shift staff had done it. R9 stated no day shift staff had offered repositioning. When R9 was administered morning medications, LPN-A told the surveyor that she had not assisted R9 with any cares that day. At 10:08 a.m. R9 again said the last time being repositioned was at 5:00 a.m. or so, and "feels stiff." The surveyor encouraged the resident to use the call light to ask for help. The director of nursing (DON) responded to R9's call light and R9 informed the DON that repositionig was needed. At 10:24 a.m., NA-B and NA-D entered the resident's room to provide morning cares.

R9's 6/2/16, Minimum Data Set (MDS) indicated the resident required extensive to total assistance with cares including repositioning. The MDS further indicated R9 had moderate cognitive impairment but did not reject cares. A pressure ulcer risk was noted, with unhealed pressure ulcers at Stage 1 or greater.

A nurse practitioner's (NP) note dated 7/20/16, revealed the resident had pressure ulcer risk factors including morbid obesity, diabetes, multiple sclerosis, and malnutrition. In addition, the NP's notes indicated the resident had a surgical flap for pressure ulcers 3/19/16, with subsequent graft failure. The medical record indicated R9 had been hospitalized 4/10/16, and had subsequently been re-admitted to the facility on 5/26/16.

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2 905	Continued From page 12 Document review of a physician's order dated 7/21/16, directed staff to provide repositioning for R9 to keep back and buttock open to air at least three times daily. 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. Document review of the policy dated 7/15, titled, Turning and Repositioning Program, directed staff to turn and reposition residents every 1-2 hours when in bed. When interviewed on 8/4/16 at 10:24 a.m., registered nurse (RN)-B verified the facility expectation was for R9 to be repositioned every two hours. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring appropriate positioning and repositioning of residents. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing this care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must	2 910		

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2 910	Continued From page 13 have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate incontinence care for 1 of 1 resident (R89) reviewed for incontinence care. Findings include: 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 (ADL's) with redirection and reapproach for refusals. During an observation on 8/2/16, at 10:29 a.m. and again 8/3/16, at 8:40 a.m. there were strong urine odors permeating on R89's person and room area. When interviewed on 8/3/16, at 8:45 a.m. licensed practical nurse (LPN)-A reported [R89] independently toileted self.	2 910		

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2 910	Continued From page 14	2 910		

During an interview on 8/3/16, at 8:59 a.m. R89 complained the staff did not provide assistance and had to do everything per self. R89 said it did no good to turn on the call light for help and boldly stated, "they won't help me."

During an observation of a wound dressing change by LPN-A on 8/3/16, at 9:36 a.m. R89 reported the need to urinate. LPN-A asked, "Do you need any help?" to which the resident replied, "I do." R89's brief was soaked with a large 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

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2 910	Continued From page 15 was sometimes "difficult" when approached for cares, however, one staff should have been assisting the resident with pericare when changing the brief. The facility's 7/15, Management of Urinary Incontinence policy directed staff to utilize the Alteration in Urinary Continence Care Plan to identify urinary problems, goals, and interventions appropriate for the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring appropriate care and services related to incontinence. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing this care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an	21390		

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immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;

F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;

G. a system for reviewing antibiotic use;

H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and

I. methods for maintaining awareness of current standards of practice in infection control.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to document complete results of the tuberculosis (TB) skin test (TST) that was given for 3 of 5 residents (R92, R93, R124) reviewed for TB screening. The facility failed to ensure a medical evaluation was completed for 1 of 5 residents (R23) with chest x-ray results. The facility failed to ensure completion of Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents for 1 of 5 residents (R23), and based on observation, interview and document review, the facility failed to implement procedures to minimize the risk for the spread of infection during wound care for 2 of 2 residents (R89, R9) observed for wound care, and to implement procedures to prevent the spread of infection during blood glucose monitoring for 2 of 2 residents (R3, R47) observed who required blood glucose monitoring.

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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 was admitted to the facility on 2/29/16, per R92's quarterly MDS dated 5/12/16. R92's immunization record dated 3/16/15, revealed R92 did not receive a 1st or 2nd step TST reading.

On 8/4/16, at 2:05 p.m. an interview was completed with the Interim IDON who was informed of the lack of TB information. The IDON stated her expectation was the facility follow their policy for TB immunizations.

The facility tuberculosis exposure control plan dated July 2015 directed "The center will administer the two-step Mantoux Purified Protein Derivative (PPD) Test to all new residents as required by State Regulations on admission unless they have documented evidence of a previous positive skin test which includes millimeters (mm) of induration...3. Obtain a chest x-ray and a medication evaluation if the resident

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21390	Continued From page 18 experiences a positive reaction to the current skin test." R89, during an observation on 8/3/16, at 8:59 a.m., revealed a wound dressing from the right shin had fallen down to the ankle area. During interview R89 informed the surveyor of "going downstairs to smoke" and explained not not asking for help, as the staff "won't help me." The surveyor suggested R89 use the call light to summon assistance. Licensed practical nurse LPN-A responded and said she would change the wound dressing. LPN-A was carrying a page from R89's medication sheet, which was placed on the contaminated bedside table next to the dressing container and under the normal saline bottle used for cleansing the wound. LPN-A informed R89 she would go to get supplies to complete the dressing change and subsequently left the room. R89 stated that every other day the dressing change was completd per self, without staffs' assistance, because they did not care. At 9:15 a.m. LPN-A re-entered room with supplies and initiated the dressing change. R89 reported to LPN-A the staff were not performing the dressing changes, LPN-A indicated she would let staff know about the concern. LPN-A washed hands, donned gloves and put plastic under R89's foot on the bed. Normal saline was poured to facilitate removal of the partially attached Tegaderm dressing covering the wound. LPN-A used scissors from R89's personal supply container to cut off soiled dressing around the ankle. During cleaning of the wound R89 requested a hat which LPN-A handed it to R89, contaminating the same gloves. LPN-A then proceeded to apply powder to R89's wound. LPN-A used the same scissors used to cut off the soiled dressing to cut clean gauze to wrap the Tegaderm dressing. LPN-A removed gloves, washed hands, returned	21390		

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contaminated scissors into clean dressing container, and left the room to return the medication sheet to nurses' station.

A physician progress note on 7/13/16, revealed R89's diagnoses included infection of right leg wound with history of basal cell carcinoma (skin cancer): "Culture per dermatology previously growing staph [bacterial infection]. Patient has completed a course of Bactrim [antibiotic]". Treatment record for 7/16/16, directed staff to change R89's dressing twice daily. Nursing notes showed multiple refusals of dressing change. Resident was instructed about importance of daily dressing changes.

R89's Minimum Data Set on 6/21/16, indicated the resident had open lesions with applications of dressings. Additionally, the assessment noted the resident had moderately impaired cognition, but did not reject care.

Registered nurse (RN)-B was interviewed on 8/4/16, at 10:24 a.m. and verified staff should have ensured R89's dressings were intact, and wound care should have been provided in a manner that promoted healing following the facility's infection control policies.

R9 did not receive infection control standards with cares and dressing change

During an observation on 8/3/16, at 10:24 a.m. R9 was assisted with repositioning and wound care by nursing assistant (NA)-D, NA-B and LPN-A. Neither NA washed hands prior to donning gloves and giving the resident a bed bath. At 10:35 a.m. LPN-A entered room to do dressing change. LPN-A donned gloves without hand washing/sanitizing and brought dressing

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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 after removing soiled packing from the wound. LPN-A verified she had not changed her gloves, and was advised to change her gloves and wash her hands.

Following the observation, RN-A verified the treatment sheets should not have been placed on R9's personal items in the room and the NA should not have placed her soiled 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.

R3 and R47 received blood glucose monitoring on 08/02/16 before the lunch meal and licensed

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practical nurse (LPN)-B used the same blood glucose monitor for both residents without properly cleaning between use.

On 8/2/16 at 10:42 a.m. LPN-B indicated was going to check two resident's blood sugars (test performed on resident with diagnoses of diabetes). LPN-B retrieved a blood glucose monitor and supplies kept in a small plastic tote and went into R3's room. At the completion of the blood glucose test, LPN-B took the tote containing the blood glucose monitor and supplies and indicated she needed to do another resident. LPN-B then went into R47's room. There was no cleaning of the blood glucose monitor, LPN-B completed the blood glucose test for R47 left the room and placed the supplies back on a shelf in the nursing station. LPN-B returned to the medication cart to review the medication record.

At 11:05 a.m. LPN-B verified the residents do not usually have their own glucometer and need to share the facility's meter to complete the tests. 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

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21390	Continued From page 22 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 for the second cleaning 7. Place 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." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to infection control and tuberculosis screening. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are delivering care according to policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis	21426		

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infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the nursing home.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to document complete results of the tuberculosis (TB) skin test (TST) that was given for 3 of 5 residents (R92, R93, R124) reviewed for TB screening. The facility failed to ensure a medical evaluation was completed for 1 of 5 residents (R23) with chest x-ray results. The facility failed to ensure completion of Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents for 1 of 5 residents (R23).

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

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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 was admitted to the facility on 2/29/16, per R92's quarterly MDS dated 5/12/16. R92's immunization record dated 3/16/15, revealed R92 did not receive a 1st or 2nd step TST reading.

On 8/4/16, at 2:05 p.m. an interview was completed with the Interim IDON who was informed of the lack of TB information. The IDON stated her expectation was the facility follow their policy for TB immunizations.

The facility tuberculosis exposure control plan dated July 2015 directed "The center will administer the two-step Mantoux Purified Protein Derivative (PPD) Test to all new residents as required by State Regulations on admission unless they have documented evidence of a previous positive skin test which includes millimeters (mm) of induration...3. Obtain a chest x-ray and a medication evaluation if the resident experiences a positive reaction to the current skin test."

SUGGESTED METHOD OF CORRECTION: The

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21426	Continued From page 25 director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide required active treatment for 1 of 1 resident (R99) reviewed for preadmission screening. Findings include: Admission record review showed that R99 was admitted on 3/24/16, with diagnoses including Down syndrome and dementia. An Evaluative Report Level II Preadmission Screening form, dated 3/28/16, listed "mental retardation" as a diagnosis for this resident. The Need For Active Treatment section of this form read, "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the	21510		

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nursing facility." The current plan of care, dated 3/25/16, did not contain active treatment interventions for R99.

During interview on 8/4/16, at 9:45 a.m. social worker (SS)-A was asked for documentation of active treatment for R99. SS-A stated that she could not locate documentation of active treatment for R99. The surveyor asked for the facility's procedure for providing active treatment for residents with a Level II Preadmission Screening that determined active treatment was needed. SS-A stated that the facility currently did not have a procedure to provide the active treatment, and this was something the facilty needed to develop going forward.

Section 3.5.1 of the facility's MI/MR Preadmission Screening policy, dated July 2015, read, "...Provide specialized services, if Level II indicates that it is required."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to Level II Preadmission Screening and provision of active treatment. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are delivering care according to policies and procedures.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21620 MN Rule 4658.1345 Labeling of Drugs (ID Prefix Tag: 21620)

Drugs used in the nursing home must be labeled

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in accordance with part 6800.6300.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure medications were stored properly in one of two med carts reviewed for medication storage, involving 3 residents (R6, R56, and R74) of 33 residents.

Findings include:

During observation during medication storage review, the facility failed to date medications such as eye drops and inhalers when opened.

During the medication storage tour on 8/2/16 at 3:15 p.m., with licensed practical nurse (LPN)-C on the fourth floor unit medication carts, observations included the following:

R6's combigan 0.2%-0.5% eye drops (a glaucoma eye drop) and Olopatadine Hcl 0.1 % eye drops (for allergic conjunctivitis) was open and was undated.
R56's Dorzolamide-Timolol 22.3-6.8/1 drops (increase eye pressure) was open and was undated.
R74's Proair HFA (rescue inhaler for asthma) was open and was undated.

On 8/2/16 3:30 p.m. with Licensed Practical Nurse (LPN)-C verified the medications were still 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

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21620	Continued From page 28 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to dating of opened medications. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are delivering care according to policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		

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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. R4's shared bathroom with R63 was observed with a large worn area in the middle of the floor, directly in front of the toilet. DM stated it was a permanent stain. MS indicated it was on the list to be replaced in about one week. R66's room window air conditioner had a large brown knob sticking outward above the controls. MS stated it was an older air conditioner and indicated the piece turned to change the air flow position. R66 had indicated did not think the room was always clean and sometimes the bathroom had an odor. MH stated the bathrooms were cleaned daily. M stated rooms were deep cleaned once a month and identified the toilet had not been flushed which could be cause the smell.	21695		

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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.

R149 had stated the room was always warm at night and the privacy curtain blocked off the air conditioning and the fan in the room. MS stated he would get a fan installed on the wall in a couple of days and M would follow up to ensure it was done.

R107's bed outside grab bar was loose. MS stated the grab bar was unlocked and demonstrated how it locked in place. The resident or staff could unlock it. MS stated his expectation was it was locked at all times.

R26' s bathroom towel rack was observed to be broken. MS stated he would remove the towel rack and put new tile in that area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00480	A. BUILDING: ______ B. WING ______	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 31 On 8/3/16, at 2:03 p.m. MH stated housekeeping policy would be provided. MS stated work order paperwork was completed on each floor at the nurse station and reports given each morning. MS further stated maintenance policy would be provided. On 8/4/16, at 12:50 p.m. observation was made on fourth floor unit of work order requests. MS stated staff could write any maintenance/housekeeping concerns which he checked first in the morning on all units. Maintenance completed those which needed to be done right away. With immediate concerns, staff paged maintenance. Undated facility 2nd floor housekeeper sheet indicated: "8:00 Begin cleaning resident rooms (using the 5 and 7 step cleaning method), 10:15 DEEP CLEAN ROOM (from posted schedule), 10:45 Continue cleaning resident rooms (Using the 5 and 7 Step Cleaning Method), 11:30 Continue cleaning resident rooms (Using the 5 and 7 Step Cleaning Method), 1:00 Continue cleaning resident rooms (Using the 5 and 7 Step Cleaning Method)"... DEEP CLEAN CHECKOFF LIST indicated: "19. Clean and disinfect toilet. 20. Clean and disinfect sink. 21. Disinfect and wipe down bathroom pull cords (NEW) 22. Clean and disinfect shower stall/tub"... Facility job title: light housekeeper dated 1/1/2000 indicated: "the light housekeeper performs a variety of tasks, such as dust mopping and damp mopping floors, cleaning and sanitizing bathrooms including sinks, tubs and commodes. They are responsible for the daily cleaning and sanitizing of patient room furniture"... Facility housekeeping policy was requested but none was provided. SUGGESTED METHOD OF CORRECTION:	21695		

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21695	Continued From page 32 The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in a manner which promoted dignity for two of two residents (R89, R9) who reported they were not treated in a dignified manner. Findings include: Based on observation, interview, and document review, the facility failed to provide services in a manner which promoted dignity for two of two residents (R89, R9) who reported they were not treated in a dignified manner. Findings include:	21805		

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21805	Continued From page 33 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. During an interview on 8/1/16, at 5:58 p.m. R89 expressed staff did not treat her with respect and dignity. R89 further stated that about one week prior, a staff member on the evening shift had answered her call light by stating abruptly, "What do you want?" The resident said she had reported the incident to a night staff. R89 stated the way the staff had spoken to her made her feel "unimportant." During observations of cares on 8/3/16, at 10:45 a.m. licensed practical nurse (LPN)-A failed to inform R89 of the process required to complete a dressing change, failed to talk with R89 during additional treatments being completed and failed to explain the steps of the treatment. R89 was upset and LPN-A failed to acknowledge that R89 was crying throughout the cares provided. R9 was assessed as cognitively intact according to the minimum data set (MDS) admission 5/26/16, and required total assistance with activities of daily living. 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 medications in the trash. LPN-A stated, "What did you do that for?" LPN-A was then observed to pick up the trash bag and leave the room. There was no explanation of what the medications were, what they were for or the importance of the	21805		

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21805	Continued From page 34 medications. LPN-A turned to leave the room when R9 asked LPN-A, "Are you going to change my dressing?" LPN-A continued to exit the room and walk down the hall without acknowledging R9. R9 called out louder, "Are you going to change my dressing?" LPN-A did not stop and return to R9's room, but called back from the hallway that she would come back after she obtained the supplies. Following the interaction R9 stated, "That made me feel ignored and unimportant." During an observation on 8/3/16, at 9:15 a.m. LPN-A returned to R9's room to perform a dressing change. During the dressing change, R9 informed LPN-A, "This hurts you know." LPN-A did not respond and continued to perform the dressing change. R9 then stated, "Ouch!" LPN-A stated to the resident, "I haven't touched it." The resident held LPN-A's arm from performing wound care. Review of R9's record, a document titled, Progress Notes, dated, 8/3/16, read, "Completed pain assessment. Resident recently had increase in pain meds...Resident to participate in cares and explain cares step by step to decrease anxiety and/or pain during cares." When interviewed on 8/4/16, at 9:50 a.m. registered nurse (RN)-B reported the expectations were for staff to follow the facility's dignity and respect policy. Staff were to introduce themselves, inform the resident regarding medications and treatments, and to engage the resident. RN-B verified the facility expectation during cares and treatments would be to inform the resident what you are doing during each step of the procedure.	21805		

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21805	Continued From page 35 Document review of the dated 7/15 policy titled, Resident Rights, included the Resident Bill of Rights which read, "Dignity/Self Determination and Participation. You have the right to receive care from the facility in a manner and in an environment that promotes, maintains, or enhances dignity and respect if full recognition of your individuality." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring that residents are treated with courtesy and respect. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are delivering care according to policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		