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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VDSH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00480

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245340**
2.STATE VENDOR OR MEDICAID NO.
(L2) **137110400**

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

4. TYPE OF ACTION: 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) **12/01/2017**

6. DATE OF SURVEY **07/31/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Mary Beth Lucina, HFE NE II 08/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/08/2018 (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)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245340

August 8, 2018

Ms. Catherine Scoville, Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

Dear Ms. Scoville:

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 July 31, 2018 the above facility is certified for:

107 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 107 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 8, 2018

Ms. Catherine Scoville, Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

RE: Project Number S5340027

Dear Ms. Scoville:

On June 22, 2018, we informed you that the following enforcement remedies were imposed:

- State Monitoring effective June 27, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 26, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on June 7, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 31, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 12, 2018 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 June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 18, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 7, 2018, as of July 31, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 31, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of June 22, 2018:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), be rescinded as of July 31, 2018.

In our letter of June 22, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 26, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 31, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2018

Ms. Catherine Scoville, Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

Re: Reinspection Results - Project Number S5340027

Dear Ms. Scoville:

On July 31, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 31, 2018, with orders received by you on June 22, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VDSH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00480

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245340**
2.STATE VENDOR OR MEDICAID NO.
(L2) **137110400**

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

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

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

6. DATE OF SURVEY **07/31/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Mary Beth Lucina, HFE NE II 08/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/08/2018 (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)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245340

August 8, 2018

Ms. Catherine Scoville, Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

Dear Ms. Scoville:

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 July 31, 2018 the above facility is certified for:

107 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 107 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 8, 2018

Ms. Catherine Scoville, Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

RE: Project Number S5340027

Dear Ms. Scoville:

On June 22, 2018, we informed you that the following enforcement remedies were imposed:

- State Monitoring effective June 27, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 26, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on June 7, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 31, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 12, 2018 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 June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 18, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 7, 2018, as of July 31, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 31, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of June 22, 2018:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), be rescinded as of July 31, 2018.

In our letter of June 22, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 26, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 31, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2018

Ms. Catherine Scoville, Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

Re: Reinspection Results - Project Number S5340027

Dear Ms. Scoville:

On July 31, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 31, 2018, with orders received by you on June 22, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VDSH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00480

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245340**
2. STATE VENDOR OR MEDICAID NO.
(L2) **137110400**

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

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

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

6. DATE OF SURVEY **06/07/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
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 :
Mary Capes, HFE NE II 07/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/22/2018 (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)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 22, 2018

Ms. Catherine Scoville, Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

RE: Project Number S5340027

Dear Ms. Scoville:

On June 7, 2018, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby significant corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

Appeal Rights – the facility rights to appeal imposed remedies; 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), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective June 27, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 26, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 26, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 26, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 26, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

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 remedy be imposed:

• Civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred

between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 26, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2018 (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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 4 through June 7, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 4 through June 7, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		7/18/18

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

Electronically Signed | 06/29/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement a plan of care based on resident preferences for 5 of 5 residents (R52, R44, R58, R50, R43) reviewed for choices. Findings include: When interviewed on 6/4/18, at 1:11 p.m. R52 who was assessed as cognitively intact 4/20/18, indicated she was in bed watching television and stated, "I think I am coming down with a cold and just want to stay in bed and watch TV." Furthermore, R52 stated, see that sign says we cannot watch TV after 10:30 pm, and when I don't	F 561	R52, R44, R58, R50, and R43 have all received a care conference to review plans of care in relation to individualized preferences regarding their plan of care. All 5 care plans have been updated to reflect changes. Resident that reside at Galtier Health Center have the potential to be affected by this practice. Resident have received notice that that television curfew has been eliminated and will be discussed at the next QAPI. Resident care conferences will cover resident choices and preferences and plans of care will be updated as appropriate. Policies and procedures	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 feel well and wake up at night I sometimes like to turn on the TV because I know my roommate does not mind." R52 indicated no one has ever talked to her about the "rule" and expressed "The rule is too strict especially if my roommate doesn't mind the television being on low." Surveyor observed a laminated sign on R52's bedroom wall that reads," Attention Residents, families and staff. All TV's are to be turned off at 10:30 p.m. This time has been determined by the Resident Council." The sign was dated 1/19/2010. When interviewed on 6/4/18, at 6:04 p.m. R44 and R58 were together is a shared bedroom. The residents were talking about choices in the facility and R44 pointed to a duplicate laminated sign observed in R52's room. R44 stated 2nd and 4th floor did not have these signs posted so he did not understand why 3rd floor had to. R44 stated, "That's not right, If I am awake during the night and want to quietly watch TV, then that should be allowed." Roommate R58 was nodding head in agreement and stated "Yes." R44 was assessed as cognitively intact 4/21/18, and R58 was assessed as cognitively intact 5/2/18. When interviewed on 6/4/18, at 6:55 p.m. R50 who was assessed as cognitively intact 4/27/18, expressed the facility's TV rule was not accommodating for R50's needs or choices. R50 explained that it is not unusual to have difficulty sleeping at night and usually having the television on for awhile during the night helps. R50 stated this has been expressed to various staff that this is not a good rule for R50.	F 561	related to resident choice and preferences has been reviewed and is current. Staff in all departments have been educated on resident rights which include; choices, preferences, and following the plan of care. Social Service/Designee will audit 3 residents weekly x 3 weeks, then 3 x monthly x 2 months to ensure resident preferences are being met. Social Service/Designee will forward results of resident preference audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 3 R43 was assessed as having mild cognitive impairment on 4/18/18. R43 expressed that the rule was "too strict" because there are times when she is not able to sleep during the night and wants the ability to turn on the television. R43 said she has asked about the rule but the staff don not seem to have an answer if the rule is accurate or enforceable. R43 requested staff ask the director of nursing for "head sets" but was told they do not work because of the way the television is connected. R43 would like the facility to obtain proper head sets so if she wakes during the night she will have the ability to watch television if she chooses. The laminated sign dated 1/19/2010, was also observed to be posted at the nurses' station. When interviewed on 6/6/18, at 8:26 a.m. registered nurse (RN)-A and the social service designee (SSD) expressed being fairly new to the third floor and not aware of the resident concerns about the restiction regarding television being used after 10:30 pm. Being the sign posted was from 2010, RN-A and SSD agreed the facility should re-visit the rule and accommodate each individual residents choices as best they could. The facility does not have a policy regarding watching television after 10:30 p.m. at night.	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 4 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 2 of 5 residents (R44, R58) reviewed who required staff assistance with personal care. The findings include:	F 583	R44 and R58 are being provided privacy with cares and are being treated with dignity and respect. NA-A has been re-educated on providing privacy and dignity with call cares. Residents that reside at Galtier Health Center have the potential to be affected by this practice. Residents that require	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 5 During interview with R44 on 6/4/418 at 5:34 p.m., R44 stated staff did not always treat her roommate (R58) or herself with dignity. During observation in of care on 6/6/18 at 7:01 a.m., a nursing assistant (NA)-A was observed to approach R58 in her room and began to provide assistance with morning care. NA-A did not pull the priviacy curtain and R44 was present in the room. NA-A washed R58's face, then continued to remove R58's clothes and washed under her breasts and the front of R58's perineum. NA-A then gestured with her hand for R58 to turn over and NA-A continued to cleanse R58's buttock. On 6/6/18 at 7:24 a.m. NA-A approached R44 and applied her stockings. NA-A then attempted to put R44's urinary catheter bag and tubing through a pair of leggings R44 was going to wear. R44 stated, "you have to empty the urine before it will fit in there." NA-A stepped away from the bedside, leaving R44 uncovered, with the privacy curtain open. R58 was present in the room at that time. NA-A left the residents' room and when she opened the door, there was a resident walking by in the hallway who looked into the room where R44 lay uncovered on her bed wearing only an incontinent brief. At that time, R44 stated, "See what I mean, she [NA-A] has an attitude and is not respectufl of me." R58 was interviewed on 6/6/18, at 8:20 a.m. and stated, "She [NA-A] does not give me privacy." R58's cognitive assessment dated 5/2/18, indicated R58 was cognitively intact. The plan of care dated 6/21/17, included interventions for staff to assist the resident with all grooming and dressing due to decrease in muscle strength and	F 583	assistance with personal cares have received care plan reviews and plans of care have been updated as appropriate. Policy and Procedure regarding dignity and privacy have been reviewed and are current. Nursing assistants and licensed nurses have been re-educated on providing privacy during cares to promote dignity. DON/Designee will complete audits on cares 3 times weekly x 3 weeks, then 3 times monthly for 2 months. DON/Designee will forward results of care and dignity audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 6 impairment of range of motion due to a history of stroke. Interventions also included: "Explain all procedures/tasks before starting and promote dignity by ensuring privacy." R44's plan of care dated 4/17/18, indicated R44 was able to participate with aspects of self care with assistance: button shirts, tie shoes, use zipper, put on shirt, pull up pants, put on socks. R44's cognitive assessment dated 4/21/18, indicated R44 was cognitively intact. During interview with registered nurse (RN)-A and social service designee (SSD) on 6/6/18 at 9:56 a.m., they verified the facility expectation was to follow the Resident Bill of Rights (which includes provision of privacy), and to treat all residents with respect and dignity.	F 583		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 7 resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a Notice of Bed Hold and Readmission for 2 of 2 residents (R1 and R14) who were transferred to a hospital. In addition, the facility failed to ensure a system was in place to consistently provide bed hold notices in a timely fashion. The findings include: R1's admission record indicated R1 was admitted on 1/4/18, with diagnosis including: Diabetes, COPD (chronic obstructive pulmonary disease), Chronic Kidney Disease, Hepatitis C, sepsis (potentially life threatening complication of an infection), pneumonia (lung infection) , C - diff (inflammation of the colon caused by the bacteria Clostridium difficile), and lung abscess with bacterial infection in the lung. Document review revealed R1 was sent to the hospital on 1/5/18, for fever and chills. A social service progress note on 1/8/18, included: " SSA informed (R1) went into hospital last Friday. She wants a bedhold; bed held." No further progress notes were written.	F 625	R14 still resides at Galtier Health Center and has not been transferred out since last acute transfer. R1 is no longer a resident. Residents that reside at Galtier Health Center that transfer out for an acute stay have the potential to be affected by this practice. The policy and procedure for resident bed hold have been reviewed and is current. Residents transferring out to the hospital will receive the bed hold notification form and social service will review with the resident. Licensed Nurses and Social Service have been educated on the bed hold policy. Social Service/designee will audit all acute transfers to ensure the resident had been provided and the bed hold form and that is has been reviewed x 3 months. Social Service/Designee will forward results of the Bed Hold audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 8	F 625		

During interview on 6/6/18 at 9:33 a.m., social service assistant (SSA)-B stated, "when a person goes to the hospital, a bed hold paper is done with the nursing paperwork. The nurses keep a copy in a binder on the nurses' floor."

During interview on 6/6/18 at 9:57 a.m., licensed practical nurse (LPN)-G stated, " the bed hold form is sent with the patient. The yellow duplicate is in the chart. If it is not in the chart it might have been sent with her." R1's closed record was reviewed, and no bed hold form was found.

The administrator verified on 6/6/18, at 11:00 a.m., R1's record lack documentation of a bed hold. The administrator indicated the facility had a new bed hold form. The administrator verified the new form did not have a place for a resident or resident's representative to sign, nor did the form indicate the resident or resident's representative was to receive a copy of the bed hold.

R14's admission record identified R14's admission date as 3/15/18, and indicated the resident had diagnoses including: hemiplegia (partial paralysis on one side of the body), type 2 diabetes melllitus, cerebrovascular disease (group of conditions that affect blood supply to the brain), hypertension (high blood pressure), anxiety disorder, major depression and systemic lupus (an inflammatory disease caused when the immune system attacks its own tissue).

During interview on 6/4/18, at 5:35 p.m., R14 and her daughter stated the facility had not provided any information about a bed hold when she was transferred to the hospital on 4/29/18. In addition, R14 stated she was not aware of the facility's bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 9	F 625		

hold policy.

Record review revealed no written documentation of bed hold information was provided to the resident/family/legal representative at the time of the hospital transfer.

A progress note dated 4/29/18 at 5:45 a.m., included: "Send to ER (emergency), concern for upper GI bleeding, per Dr ..."

A progress note dated 4/29/18 at 6:45 a.m., included: "EMTs (Emergency Medical Technician) took resident to the ER at [local hospital] for evaluation d/t (due to) bloody emesis. Family was notified."

On 6/6/18, at 1:14 p.m., registered nurse (RN)-A stated the facility had a form that should be used during hospital transfers for bed hold. RN-A verified that the medical record lacked signed written documentation of a bed hold and stated, the facility staff will be reeducate regarding bed hold policy.

On 6/6/18, at 1:35 p.m., the facility's social services director (SSD) confirmed the medical record lacked signed written documentation of a bed hold for R14. The SSD stated she'd spoken to R14's daughter but did not document it. At 3:30 p.m., the SSD stated she'd just spoken with R14's daughter and explained the bed-hold policy moving forward for hospitalization.

The facility's policy BED HOLD AND RETURN GUIDELINE undated, included: "it is the practice that residents who were transferred to the hospital or go on a therapeutic leave are provided with written information about the State's bed hold

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 10 duration and payment amount before the transfer... Residents and their representative will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave. The facility will maintain in contact with the resident and representative while the resident is absent from the facility and arrange for their return if appropriate..."	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care conferences were held after each assessment, and failed to include the resident in the care planning process for 2 of 3 residents (R43 and R52) reviewed for care planning. Findings include: When interviewed on 6/5/18, at 8:26 a.m. R43 expressed concern about staff being aware of preferences for care, and awareness of her food allergies. When asked about the plan of care and participation in the plan of care, R43 stated, "I have never seen my plan of care, and I can't remember meeting about my plan of care." R43's cognitive assessment dated 4/18/18, indicated R43 had mild cognitive impairment. When interviewed on 6/6/18, at 8:44 a.m. registered nurse (RN)-A and the social service designee (SSD) verified they were not aware of R43's concerns. When asked about her participation in care conferences, RN-A and SSD discovered R43's last care conference had been held on 1/26/18, and stated R43 and her family had attended. RN-A and SSD stated R43's quarterly care conference had been missed in April/May, and stated they had been waiting to hear from R43's family about when they could attend. When interviewed on 6/4/18, at 1:00 p.m. R52 stated, "I am very upset about my weight gain and the facility will not help me, and won't even give me a salad, today is a perfect example because I	F 657	R43 had a care conference, resident was present and family/representative was invited. Resident preferences and plan of care was reviewed with the resident and updates were made as appropriate. R52 was present during his care conference and resident representative was invited, dietician was also present. Weight and diet goals discussed with resident with resident preferences integrated into the plan of care. Resident that reside at Galtier Health Center have the potential to be affected by this practice. Admitting residents will have an initial care conference within the first 48 hours of admission with preferences and plan of reviewed and individualized with the resident. All care conferences scheduled then after to include an invitation to the resident, resident representative, and whomever the resident choses to invite. Care conferences will honor resident choices and care plans will be updated to reflect preferences. Registered dietician will meet with all residents to ensure dietary plan of care, goals, and resident food preferences are current and up to date. Social service, Nursing, and dietary have been educated on care conferences and honoring resident choices with care plan updates made to reflect. Administrator/designee to audit care conference schedules and care plan updates weekly x 4 weeks, then 4 times a week monthly x 3 months. Administer/Designee will forward results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 12 asked for a salad at lunch time and was told they did not have any salad." When interviewed on 6/6/18 at 9:25 a.m. RN-A and SSD verified the last care conference held for R52 was documented as 2/27/18. They also confirmed the dietitian had not been in attendance. They stated R52's quarterly care conference due for the end of May was overdue, but would be scheduled soon. R52's weights were reviewed. An admission weight was documented on 4/30/17 to be 135 pounds. R52's current weight was documented as 161 pounds. According to care conference notes, the last quarterly care conference had been held on 2/27/18, with the resident and guardian present. On 3/7/18, the dietitian documented in the Nutritional Monitoring and Evaluation section of the chart, "current weight 150 # is 111% IWR (ideal weight range); planned weight gain since November weight of 119#, increase 30# /180 days from 120#(25%). Although weight increase to slightly above healthy range, res (resident) benefits from gain with adequate intake. Nutritious Juice d/c (discontinued) 3/5 (3/5/18) 2/2 (secondary to) gain... po (oral) intake range from 75-100% of meals providing 1700-2200 cal/meals (calories from meals) plus HS (hour of sleep) snack...needs increased slightly 2/2 weight gain...Continue POC (plan of care). There was no documentation to indicate the dietitian had discussed R52's weight gain or the risks and benefits associated with the weight gain with the resident at the time of the care conference, or since.	F 657	of the Care Conference audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 13 When interviewed on 6/6/18, at 9:41 a.m. the registered dietitian (RD) stated she was new to the facility, and had worked there about four weeks. The RD reviewed the documented assessments from the previous RD, and verified a dietitian had not met with the resident. The RD verified the resident should have been involved with the nutritional plan and stated she would meet with the resident as soon as possible. A policy was requested regarding the scheduling of care conference's but none was provided by the time of the exit.	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to protect the skin and prevent further breakdown of a facility acquired pressure ulcer for 1 of 3 residents (R65) reviewed for	F 686	R65 wound has been re-assessed with measurements reviewed, new interventions were put into place, MD updated, new orders for Prafo Boot to left heel, Registered Dietician reviewed	7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 14 pressure ulcers. The failure of the facility to consistently implement ordered interventions, and reassess the effectiveness of the interventions in a timely manner, resulted in the deterioration of a facility acquired pressure ulcer from a stage II to an unstageable ulcer, which resulted in harm for R65. Findings include: On 6/4/18, at 1:43 p.m. R65 was observed laying in bed. R65 was positioned on his back, and covered by a sheet. Under the sheet, R65 had positioned both heels pulled up towards the buttocks, so his knees were bent and in the air as he appeared to be digging both heels into the mattress. There was a light blue structured walking boot with Velcro straps on the bedside table, and another style of unstructured boot that was smaller, soft, and dark blue, in the corner of the bed on top of the sheet. When questioned what the boots were used for, R65 was confused, asking what boots? After pointing to the boots on the bedside table and bed, R65 was unable to state when they were used, and said they were worn in the winter to help with the cold. During observation on 6/5/18, at 9:32 a.m. R65 was asleep in bed. Again, R65 was positioned laying on his back, with both heels pulled up toward his buttocks, with his knees in the air. R65's heels were pressed into the mattress on the bed, and he had a thin sheet pulled up over himself. R65 did not appear to have boots on either foot, as the outline of the foot and toes could be seen under the sheet. The structured light blue boot was observed on the bedside table.	F 686	resident plan of care and made updates as appropriate, new treatments orders in place, and care plans updated. Residents that resident Galtier Health Center with current wounds have the potential to be affected by this practice. New assessment were completed on residents with wounds and are documented in wound rounds. Interventions for wounds have been reviewed with updates made as appropriate. All new or worsening wounds will have a physician notification with intervention reviews and plan of care updates made. Licensed Nurses have been educated on ensuring physician ordered interventions in place in regards to residents with wounds, notifying the physician of new or worsening wounds, and completing routine assessments and placing in the wound rounds software. DON/designee to audit wounds daily x 4 weeks in wound rounds to ensure appropriate follow up occurring for wounds with changes, in addition auditing will occur 3 times weekly x 4 weeks for residents with specific interventions for pressure relief to ensure that they are in place. DON/Designee will forward results of the resident wound audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 15	F 686		

During observation on 6/5/18, at 3:56 p.m. R65 was observed lying in bed under a thin, white knit blanket. R65 was not wearing shoes or boots as the outline of the foot and toes could be seen under the knit blanket. R65 was supine, laying flat on the back, with legs straight and both heels resting on the mattress.

During interview on 6/5/18, at 4:23 p.m., registered nurse (RN)-D did not believe R65 had any current skin concerns, but wanted to check the eMR (electronic medical record) to be sure. RN-D said R65 had only been living on the unit for about 2-3 weeks. RN-D looked in the eMR and reported that R65 had a history of a closed buttock ulcer, a left heel ulcer, and orders to reposition the resident every two hours.

On 6/6/18, at 7:06 a.m., R65 was observed sitting up in a wheelchair in his room with socks on both feet which were resting on the footrests. At 7:08 a.m. R65 propelled himself in the wheelchair into the hallway. He used both arms to slowly move the wheels little by little, and also moved his feet off the foot pedals, pulling the chair along by digging his heels into the floor and pulling. At that time, licensed practical nurse (LPN)-K greeted R65 and stated, "Let's get your boots on." LPN-K stated to nearby staff, "[R65] needs to wear [his/her] boots all the time." At 7:10 a.m. R65 again propelled self out of the room in the wheelchair. R65 was now wearing the soft, dark blue boots on both feet. The boots covered the heels and sides of the feet, and did not appear to have any firm support, but rather offered a soft, comfort type cushion. The entire top of the boot was open, exposing the top of the foot, except for a single strap over the foot near the ankle. R65 was observed to wander the hallway in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 16	F 686		

wheelchair until 7:20 a.m. when staff offered to push R65 to the dining room for breakfast. At 7:47 a.m. R65 moved around the dining room in the wheelchair using his feet to dig into the floor to pull himself, using his arms to push the wheels a little at a time. The soft left boot was observed to have slid off R65's heel and was twisted sideways.

After breakfast at 8:58 a.m. on 6/6/18, R65 was observed propelling himself back to his room. The left boot was still twisted and was observed to be sliding off the foot, leaving the left heel unprotected. At 9:01 a.m. staff entered R65's room and removed the boots prior to transferring R65 to the toilet. At 9:09 a.m. staff put the soft boots back on R65's feet before leaving R65 in the wheelchair to watch a movie in the room, per the resident's request.

During interview on 6/6/18, at 10:06 a.m. the director of nursing (DON) discussed the measurements of the left heel pressure ulcer. The DON explained that a nurse assessed the wound weekly, and that it could be a nurse manager or a nurse on duty. After assessing, the nurse input the description and measurements, along with pictures of the wound, in the electronic wound tracking system. The DON pulled up current treatments in the electronic wound tracking system and it was noted all current treatments had been initiated on 2/23/18: a high calorie supplement, leaving the wound open to air, keeping heels off the bed, using an ointment, and a low air loss mattress. The DON stated she did not see current treatments for the right wound, but thought the treatment should be the same as the left. The DON reviewed the weekly measurements and said the left heel wound had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 17	F 686		

almost closed in April, but had then started scabbing again. The DON confirmed the most recent wound measurements were from 6/4/18, and measured 10.0 centimeters (cm) x 6.0 cm, which was larger than prior measurements (3.5 cm x 3.0 cm on 6/1/18, 2.0 cm x 2.0 cm on 5/7/18). The DON stated she was concerned about the accuracy of how nursing staff measured the wound. In the pictures, staff held up a flexible ruler next to the skin opening to show the wound size, some staff appeared to measure straight across the wound, while others wrapped the ruler around the ankle to measure. The DON stated she was concerned about the large jump in documented measurements from 6/1/18 (3.5 cm x 3.0 cm) to 6/4/18 (10.0 cm x 6.0 cm), and would ask nursing staff to re-measure the left heel wound to confirm size.

On 6/6/18 at 10:35 a.m., R65 was observed to be supine in bed. The covers were turned down, so R65's legs and feet were visible. R65 was not wearing boots, had a sock on the right foot, but nothing on the left foot. R65's heels rested on the bed. The light blue structured boot was missing from the bedside table, and the soft, dark blue boots were on the floor. LPN-K and LPN-D entered the room and prepared to assess and re-measure the left heel. At 10:38 a.m. LPN-K asked LPN-D why the dark blue boots were on the floor and stated, "[R65] needs to wear them at all times." LPN-D did not know why the boots were on the floor, but stated R65 sometimes removed them. The bandage on the left heel was balled up and starting to fall off. LPN-D removed the bandage, and washed the wound. There was a large, dry flap of skin still partially attached on one side, and above the flap was a dark purple/black scab type area. At 10:41 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 18	F 686		

LPN-D measured the the entire area as 7.0 cm x 5.0 cm, and measured the dark area as 4.5 cm x 2.5 cm. LPN-K stated the wound was categorized as unstageable, because there was no way to know how deep the wound went underneath the dark, scabby tissue. LPN-D applied an adhesive foam dressing to the wound, before getting clean socks for R65, as the wound drainage had left rusty, brown spots on the inside of the sock.

Review of the R65's admission record documentation revealed R65 was admitted to the facility on 1/30/18, with diagnoses including: Alzheimer's disease, generalized muscle weakness, and peripheral vascular disease. During the most recent quarterly Minimum Data Set (MDS) assessment dated 5/7/18, staff had assessed R65 to be severely cognitively impaired, with a brief interview for mental status (BIMS) score of 3 (indicating severe cognitive impairment). The care area assessment for the most recent annual MDS dated 2/6/18, indicated R65 was at risk for pressure injury due to dependence on staff for activities of daily living, mood/behaviors, and pain. In addition, R65 was assessed to be reluctant to move or change position due to pain, and staff were to provide off loading and repositioning to prevent pressure. Further the assessment indicated licensed staff were to observe for indications of pressure or skin breakdown.

Review of the wound record in the electronic medical record (eMR) revealed R65 currently had two pressure ulcers; one on each heel. The right heel blister was currently categorized as unstageable, was acquired in the facility, and was identified on 5/22/18. The left heel blister was currently categorized as unstageable, also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19	F 686		

acquired in the facility, and was identified on 2/20/18. Pressure Ulcer Documentation Guidelines provided by the facility, and written by the National Pressure Ulcer Advisory Panel, described an unstageable pressure ulcer as being a wound with full thickness tissue loss in which the base of the ulcer is covered by slough (devitalized tissue that is yellow, tan, gray, green or brown) and/or Eschar (dead tissue that is tan, brown or black) in the wound bed. Until the slough/eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined.

On 6/6/18 at 11:40 a.m., copies of the current nursing assistant care guide was requested. At 3:28 p.m. the DON provided an undated copy of the nursing assistant care guide, which directed nursing assistants to ensure R65 wore Spenco boots on both feet. Under the special requirements section, there was guidance for R65 to wear Spenco boots at all times to protect R65's heels, and that R65 was being fitted for PRAFO boots (custom fitted supportive boots that keep all pressure off heels). The guidance also indicated staff were to provide wound treatments for the heels, and were to turn and reposition R65 every 2-3 hours while in bed.

A progress note written on 6/6/18, at 1:13 p.m. included: "[Nurse Practitioner] updated and this writer received orders for PRAFO boots to be ordered; will be here at 3 PM to fit [R65] for the boots today".

On 6/7/18, at 7:45 a.m. R65 was observed sleeping in bed under a sheet. R65 was laying on his back, and there appeared to be a pillow under R65's knees, because both knees were bent and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20	F 686		

slightly elevated. The two soft, dark blue boots were observed on the floor next to the bed, and next to them sat a new pair of PRAFO boots. R65 was not observed to be wearing boots as both heels rested on the mattress.

On 6/7/18, at 7:51 a.m., LPN-D stated R65 was supposed to be wearing the soft, dark blue boots when R65 was up, and that they should also be on when R65 was in bed. LPN-D also stated R65 did not like to wear the boots, but that they should be on in bed because R65 always dragged both heels against the mattress in bed, which could cause pressure. LPN-D looked in the room at R65, and confirmed R65 was not currently wearing any protective boots. At 8:02 a.m. nursing assistant (NA)-C stated, "[R65] has little booties which [R65] is supposed to wear pretty much all the time." NA-C said this was not a new intervention, but mentioned that R65 was newer to this unit.

On 6/7/18, at 8:22 a.m. the DON confirmed R65 got PRAFO boots fitted yesterday. The DON described how R65 liked to take his/her feet off the foot pedals when seated in the wheelchair, and rest heels on the floor, pulling his/her bodyweight along in the wheelchair using the heels. The DON said this was how R65 propelled himself around the unit. The DON said the soft, little dark blue boots would twist and come off while R65 moved around the unit in this manner, but the new PRAFO boots were less likely to fall off. The DON said there was a new order created yesterday, which required R65 to wear the PRAFO boots at all times. Before the PRAFO boots, the order was for R65 to wear the Spenco boots at all times, although the DON said R65 did not always like to wear them. The DON explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21	F 686		

that when it came to special order footwear, such as the PRAFO boots, therapy first assessed what was appropriate, and then the physician got involved to approve ordering the special footwear. When asked why the PRAFO boots were just ordered yesterday, the DON replied that when the size of the wound recently got bigger, staff looked at the interventions currently in place, and determined that the interventions obviously were not working. Again the DON described how the soft little boots staff were putting on R65 would not stay in place, and would twist around on R65's feet because the resident was very active and self propelled the wheelchair using the feet.

On 6/7/18, at 8:30 a.m. R65 was observed with the new PRAFO boots on, which had a hard plastic piece that curved around and away from the heel, providing space between the heel and the boot to protect the heel from pressure, and ensure the heels were floated off the bed.

In a follow-up interview on 6/7/18, at 8:37 a.m. the DON was asked why some of the nursing staff did not seem to be aware of R65's pressure ulcers when asked if R65 had any skin concerns. The DON said R65 had moved onto the unit from another floor on 5/7/18, but explained that all the regular staff on the floor should know about R65's heel ulcers. The DON said that even if staff floated on the unit to fill in, and did not typically work on the unit, the details of R65's care were written on the nursing assistant care guide, so all staff should know what R65 needed. The DON again reviewed the left heel ulcer measurements, and noted that the increase in size had occurred after R65 moved onto the new unit. The DON wondered out loud if the new staff needed time to adjust to R65's cares, and get to know R65 after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22	F 686		

the move. The DON said that the left heel wound previously looked like it was getting better, but had then gotten bigger. The DON questioned whether there was a communication issue, which could be why staff were not all aware of what was supposed to be happening to protect R65's heels.

During interview on 6/7/18, at 10:37 a.m. the physical therapy assistant (PTA) confirmed meeting with R65 the day before at the request of nursing staff. PTA said nursing called, and described the manner in which R65 dug both heels into the ground to pull self along in the wheelchair. PTA remembered working with R65 earlier that winter, and confirmed that R65 was in a wheelchair at that time too, and also self propelled in the chair by using a combination of arms and feet. After being called by nursing yesterday, PTA quickly took a look at R65 before contacting the orthotic company to request fitting R65 with PRAFO boots. PTA said the orthotics company was able to come out quickly to the facility yesterday afternoon to fit R65 with the boots.

During interview on 6/7/18, at 11:05 a.m. the administrator provided a new nursing assistant care guide, and explained that it had been updated today. The updated care guide included R65's need to wear PRAFO boots at all times on both feet to protect and float the heels, and to encourage R65 to keep boots on. The guide was also updated with the requirement that R65 be turned and repositioned every 20 minutes while in bed.

During interview on 6/7/18, at 12:14 p.m., the registered dietitian (RD) described having a conversation with the unit manager about R65.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23	F 686		

RD explained being made aware of the skin breakdown yesterday, and as a result, added Pure Protein (protein shake) and Juven (nutrition powder for wound healing) to R65's diet. RD explained R65 was previously taking a high calorie supplement which had some protein, but not as much as what R65 currently needed; hence adding Pure Protein and Juven. RD explained how the nutritional supplements needed by any resident really depended on factors such as a resident's body size, and what was going on with a wound. RD said that R65 needed the extra nutritional supplements added, as R65's needs had increased drastically with the wound breakdown.

A progress note written on 6/6/18, at 3:20 p.m., indicated "RD followed up with [unit manager] regarding resident's unstageable [pressure ulcer]. Per [unit manager], resident with history of pressure ulcers and had a stage II [pressure ulcer] on heel. Resident uses [his/her] heels to pull [his/her] wheelchair and resident drags [his/her] heel against the mattress when in bed. [Unit manager] feels this is what caused resident's heels to open. RD will continue to follow."

Review of pertinent orders revealed the following:
-2/26/18. Left heel blister measuring 4.5 centimeters (cm) x 4.0 cm noted on 2/20/18. Keep clean and dry, monitor for signs and symptoms of infection, or further signs and symptoms of breakdown. Spenco boots on both feet at all times, keep heels off the bed.
- 2/26/18. 120 cubic centimeters (cc) of Hi-Cal (high calorie supplement) three times a day.
-2/26/18. Apply Vitamin A and D ointment to both feet and legs twice daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24	F 686		

- 2/26/18. Turn and position resident every 2 hours and as needed.
-5/22/18. Order for off load boots for "2/2 heel blisters; therapy updated."
-6/6/18. PRAFO boots to be worn at all times to make sure that heels remain offloaded.
- 6/6/18. Left heel ulcer: monitor for signs and symptoms of infection, or further signs and symptoms of breakdown. Bilateral float boots on at all times, keep heels off the bed.
- 6/6/18. One packet of Juven two times a day for wound healing.
- 6/6/18. 60 cc Prostat Sugar Free AWC (advanced wound care) nutritional supplement two times a day for wound healing.

On 6/5/18, review of the current care plan in the eMR confirmed R65 had the potential for a pressure ulcers related to dermal (skin) frailty, decreased mobility, inadequate nutrition, and dehydration. The care plan described R65 as having history of prior pressure ulcers that had scabbed over and closed. The care plan noted the fluid filled blister to the left heel on 2/20/18. The care plan did not mention the pressure ulcer on the right heel. Interventions included administering treatments as ordered and monitoring for effectiveness. The care plan directed staff to avoid positioning R65 on the left heel, and to keep heels off the bed at all times with bilateral Spenco boots. Additionally, the care plan required staff to monitor the dressing each shift to ensure it was intact and adhering, and assess and record wound healing weekly, by measuring length, width, and depth where possible. Staff were to report improvement and declines to the Medical Doctor. On 6/6/18 at 11:40 a.m. a copy of the care plan was requested. A portion of the care plan was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25	F 686		

provided, but failed to include the section about pressure ulcers, so unable to determine when the care plan had been last updated at the time of review on 6/5/18.

The most recent physician progress note in the chart at the time of review on 6/7/18, was for an encounter dated 4/12/18. The note had the following written about pressure ulcers: "Left heel wound. [Continue] local cares, use Spenco boots." The most recent nurse practitioner progress note in the chart was for an encounter on 3/23/18, and did not mention anything regarding pressure ulcers. The physician progress note from a 3/15/18 encounter did not mention anything regarding pressure ulcers. The nurse practitioner progress note from a 3/8/18 encounter noted, "Left heel dry skin with old blood under from previous blister," and "Continue to protect and relieve pressure."

The facility utilized WoundRounds, a computer module for monitoring wounds. The module included a Pressure Ulcer Scale for healing (PUSH) score which, according to the National Pressure Ulcer Advisory Panel, is a scoring system that helps compare the improvement (decreasing PUSH numbers) or deterioration (increasing PUSH numbers) of a wound. The PUSH number was calculated each time the wound was assessed, using data collected such as the wound size, drainage amount, and tissue types.

Review of the weekly wound monitoring revealed the following history of the right heel pressure ulcer:
-5/22/18: Clinical stage: unstageable (full thickness tissue loss in which the base of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 26	F 686		

ulcer is covered so the true depth can not be determined.) Tissue type: 100% intact skin. 7.0 cm x 4.0 cm, depth unknown. No drainage. PUSH 11.
-6/1/18: Clinical stage: Unstageable. Tissue type: 25% bright pink or red. 6.5 cm x 3.5 cm, depth unknown. No drainage. PUSH 11.
-6/4/18: Clinical stage: Unstageable. Tissue type: 100% slough (yellow, devitalized tissue) loosely adherent. 6.5 cm x 3.5 cm, depth unknown. No drainage. PUSH 12.

Review of weekly wound monitoring revealed the following history of the left heel pressure ulcer:
-2/23/18: Clinical stage: Stage II (Partial thickness loss of dermis). Tissue type: 100% blood filled blister. 4.5 cm x 4.2 cm, with no depth. Moderate serosanguineous drainage (contains serum and blood). PUSH 12.
-2/26/18: Clinical stage: Stage II. Tissue type: 100% blood filled blister. 3.5 cm x 4.0 cm, with no depth. Moderate serosanguineous drainage. PUSH 12.
-3/5/18: Clinical stage: Stage II. Tissue type: 100% blood filled blister. 3.5 cm x 3.5 cm, with no depth. Moderate serosanguineous drainage. PUSH 12.
-3/12/18: Clinical stage: Stage II. Tissue type: 100% blood filled blister. 3.5 cm x 3.5 cm, with no depth. Moderate serosanguineous drainage. PUSH 12.
-3/22/18: Clinical stage: Stage II. Tissue type: 50% purple ecchymosis (subcutaneous bleeding), 50% slough loosely adherent. 4.0 cm x 3.5 cm, with no depth. Light serosanguineous drainage. PUSH 13.
-3/27/18: Clinical stage: Stage II. Tissue type: % purple ecchymosis (subcutaneous bleeding), 50% slough loosely adherent. 4.0 cm x 3.5 cm, with no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27 depth. Light serosanguineous drainage. PUSH 13. -4/2/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red (often indicative of healthy, healing tissue), 50% slough loosely adherent. 4.0 cm x 3.5 cm, with no depth. Light serosanguineous drainage. PUSH 13. - 4/10/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 4.0 cm x 3.5 cm, with no depth. No drainage. PUSH 12. -4/16/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 2.0 cm x 3.0 cm, with no depth. No drainage. PUSH 10. -4/23/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 2.0 cm x 3.0 cm, with no depth. No drainage. PUSH 10. -5/2/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 2.0 cm x 3.0 cm, with no depth. No drainage. PUSH 10 -5/7/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 2.0 cm x 2.0 cm, with no depth. No drainage. PUSH 9. -5/16/18: Clinical stage: Unstageable. Tissue type: 45% blood filled blister, 55% purple ecchymosis. 4.0 cm x 5.0 cm, depth unknown. No drainage. PUSH 10. -5/22/18: Clinical stage: Unstageable. Tissue type: 65% deep maroon, 35% slough loosely adherent. 3.5 cm x 3.0 cm, depth unknown. No drainage. PUSH 11. -6/1/18: Clinical stage: Unstageable. Tissue type: 65% deep maroon, 35% slough loosely adherent. 3.5 cm x 3.0 cm, depth unknown. No drainage. PUSH 11.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28 -6/4/18: Clinical stage: Unstageable. Tissue type: 55% slough non-adherent, 45% necrotic (dead) hard adherent. 10.0 cm x 6.0 cm, depth unknown. Moderate serosanguineous drainage. PUSH 16. -6/6/18: Clinical stage: Unstageable. Tissue type: 50% deep maroon, 50% slough loosely adherent. 7.0 cm x 5.0 cm, depth unknown. Moderate serosanguineous drainage. PUSH 15. The Skin Management Guideline, effective 11/28/17, had the following purpose: "To ensure residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown." Additionally, per the guideline, a complete, comprehensive evaluation guides the identification of residents at risk, and factors predicting the risk for breakdown; identification of interventions to stabilize, reduce or remove underlying risk factors; evaluate the effectiveness of interventions; modify the interventions as appropriate. The dietitian will be notified upon discovery of a wound, when a wound declines unexpectedly, and if a wound is not showing progress in 2-4 weeks. A therapy evaluation will be requested for positioning and treatment as appropriate upon admission and with a change in condition. Evaluate interventions per risk factors identified and re-evaluate and modify the plan of care based on root cause analysis for new skin alterations. Consult with a physician/nurse practitioner, family and supervisor/designee if the ulcer(s) has not shown progress in two weeks. Consult with the physician/nurse practitioner if the wound is deteriorating or increases in size. Re-evaluate plan of care as appropriate.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29 Post survey, on 6/9/18, at 9:31 a.m. the administrator forwarded information by email that had not been provided during survey. The documentation provided post survey indicated the interdisciplinary team had reviewed R65's status and had updated the resident's care plan to include: 1. Therapy recommended Prafo boots on at all times 2. Interventions were placed in the [point of care] Task list to monitor resident self-removal/displacement of the brace. 3. An air mattress was ordered. 4. Care delivery guides updated to reflect the changes. In addition, the email indicated the interdisciplinary team had completed an action plan on 6/7/18, regarding proper assessment and staging of pressure ulcers, including education with proper positioning, placement, and pictures utilized for WoundRounds. The information provided did not diminish the facility's responsiblity to ensure interventions prescribed should have been implemented, and did not diminish the fact the resident's heel ulcer had increased from a Stage II to an unstageable ulcer.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 30 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the	F 758	R17's received a medication review from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 31 facility failed to monitor for potential adverse consequences for 1 of 5 residents reviewed (R17) for unnecessary medications. Findings include: Review of the facility's Psychotropic Medication Management policy, effective 11/28/17, defined adverse consequence as "an unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status." The adverse consequence procedure clarified, "Residents on psychoactive medications are monitored daily for adverse consequences," and directed staff to contact the medical doctor or nurse practitioner regarding any medication-related adverse consequences. Psychoactive Medications were defined as any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders. Review of R17's Admission Record revealed R17 had diagnoses including unspecified dementia without behavioral disturbance, major depressive disorder, and intracranial injury. Review of current medication orders and the medication administration record (MAR), indicated R17 utilized the following psychoactive medications: Aripiprazole (antipsychotic medication also known as Abilify) 20 milligrams (mg) daily to treat depression and traumatic brain injury with psychotic features; Bupropion (antidepressant medication) 150 mg daily to treat major depressive disorder, Trazadone (antidepressant medication) 200 mg at bedtime for insomnia, and Venlafaxine (antidepressant	F 758	the physician and pharmacist with recommendations implemented and side effect monitoring put in place. R17s target mood and behavior program was reviewed with program revised and plans of care updated. Residents at Galtier health Center that receive a psychoactive medication have the potential to be affected by this practice. Residents that receive psychoactive medications have received a medication review with side effect monitoring put in place. Target mood and behavior programs have been reviewed and updated as appropriate. Nursing management and Social services have been educated on ensuring medication monitoring is in place as well as ensuring that residents on psychoactive medications have target mood and behavior plans in place. Social Services/designee will audit for side effect monitoring and target mood and behavior programs once weekly x 4 weeks to ensure in place. Social Services/Designee will forward results of the psychotropic medication monitoring audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 32	F 758		

medication also known as Effexor) 225 mg daily for major depressive disorder.

According to the most recent annual Minimum Data Set (MDS) assessment dated 12/22/17, R17 had received antipsychotic and antidepressant medications daily during the 7 day look back period. A Care Area Assessment (CAA) for the area of psychotropic drug use indicated: "[R17] receives psychotropic [medications] for management and treatment of psychosis, depression, and insomnia. Staff observe for potential side effects, effectiveness of [medications], and any mood/behavioral indicators. Monitored per [medical doctor] and facility policy."

R17's current electronic record care plan reviewed 6/7/18, indicated R17 used antipsychotic medications related to the diagnosis of depression with psychotic features, and auditory hallucinations. The care plan listed the goal of no negative outcomes resulting from use of antipsychotic medications, and to be free of drug related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment. The care plan noted use of antidepressant medications related to diagnosis of depression, and listed a goal for R17 to be free from discomfort or adverse reactions related to antidepressant therapy. The care plan also indicated R17 had a potential risk for alteration in psychosocial well-being related to depression, and long time use of psychotropic medications. An intervention indicated staff were to administer medications as ordered, and monitor for/document side effects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 33	F 758		

During interview on 6/7/18, at 10:18 a.m. licensed practical nurse (LPN)-E said any required side effect monitoring was completed by the nurses on the treatment administration record (TAR).

Review of the MARs and TARs failed to provide evidence staff monitored R17 daily for potential side effects or adverse consequences from psychotropic medication use.

During interview on 6/7/18, at 1:17 p.m. the director of nursing (DON) confirmed nurses should be monitoring and documenting side effects daily on the TAR. The DON reviewed the TAR and was unable to find evidence of daily monitoring. The DON said the facility had switched from paper MAR and TAR forms, to electronic forms in February 2018. The DON explained that side effect monitoring was automatically printed on the paper MAR/TAR forms, but when the facility switched to use of the electronic MAR/TAR, the daily side effect monitoring had to be entered as an order before the monitoring would show up as a daily task. The DON confirmed nursing staff had not been monitoring R17 daily for side effects on the TAR, and believed this had happened since the February switch to the electronic MAR/TAR. During the course of the interview, the DON entered an order for nursing to monitor R17 daily for side effects.

The facility's consultant pharmacist had documented a recommendation for R17 on 6/5/18: "Use of two or more antidepressants simultaneously may increase risk of side effects; in such cases, there should be documentation of expected benefits that outweigh the associated risks and monitoring for any increase in side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 34 effects." The pharmacist recommended re-evaluation of the need/benefit for the three antidepressants and antipsychotic medications, and if the therapy was to continue, recommended the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences such as dizziness, nausea, diarrhea, anxiety, nervousness, insomnia, somnolence, weight gain, anorexia, or increased appetite or falls.	F 758		
F 806 SS=F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate 2 of 2 residents' (R52, R14) preferences for food choices. This had the potential to affect all 83 residents who received meals provided by the facility. Findings include: During an observation of the third floor dining room on 6/4/18, at 12:00 p.m. R52 stated, "I don't want the pork and they took away our alternates last week without telling us why."	F 806	Alternate meal choices have been re-implemented and R52 and R14 have been updated. Residents that reside at Galtier Health Center have the potential to be affected by this practice. Menus have been reviewed and modified to reflect the alternate meals for each meal time and is posted for residents on each floor. Dietary manager, culinary aids, and nursing services have been educated on offering alternative meals during each meal time.	7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 35 Review of the posted menu, located on a bulletin board in the dining room, verified pork was being served for lunch. No alternate choice was listed. When interviewed on 6/4/18, at 12:10 p.m. dietary aide (DA)-A stated, "There is no alternate, they took those away last week." DA-A verified alternative meal options were no longer available, and stated no explanation had been provided by management. On 6/4/18 at 5:28 p.m., R14 stated, "Rresidents had an alternative food option before but have not since this new company took over. I call my daughter to bring food for me, if I don't like what they serve. You cannot even call downstairs for a sandwich, it's bad". During the evening meal on second floor on 6/4/18 at 5:54 p.m., DA-B was interviewed about whether there was an alternate meal if a resident wouldn't want what was being served. DA-B stated the facility no longer had alternate meals. During an observation of the third floor dining room on the evening of 6/4/18, at 6:15 p.m. multiple residents were heard discussing how upset they were regarding the removal of alternative meal option. Review of the posted menu on the bulletin board in the dining room indicated tacos were being served for dinner. No alternate choice was listed. When interviewed on 6/4/18, at 6:20 p.m. DA-B stated, "They stopped offering alternatives a week ago and no one told us [employees or residents] why." When interviewed on 6/5/18, at 8:30 a.m.	F 806	Dietary Manager/designee to audit meal service, offering of alternative meals, and availability of alternate meals 3 times a week x 4 weeks. Dietary manager/Designee will forward results of the meal service audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 36 registered nurse (RN)-A and the social service designee (SSD) verified there were no longer alternate meal options being provided since "last week". They said they thought it had something to do with the new management but stated they had not been involved in the discussion, or planning process. RN-A said she'd reported to the dietary manager already last week, that residents were complaining about having the alternate food choices taken away. During an interview on 6/5/18, at 11:54 a.m. the facility's regional culinary director confirmed there had been no alternate meal options the day before, but said she was unaware of the issue until later. She stated, "There should always be an alternate meal option for residents to choose from. The goal is for the facility to move to a menu with one chef special of the day, in addition to a menu with items that are always available for residents to choose from." A policy regarding alternate food choices was requested but not received at the time of the exit conference.	F 806		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement infection control practices to minimize and prevent the spread of infections. Staff failed to appropriately implement hand hygiene during personal care for 2 of 5 residents (R44 and R58); failed to utilize sanitary technique for emptying a urinary drainage bag for 1 of 1resident (R44) observed for catheter care; failed to maintain sanitary conditions for 3 of 3 medication rooms; and failed to ensure 5 of 5 medication carts were maintained in a sanitary condition. Findings include: R44 was interviewed on 6/4/18 at 5:34 p.m., and stated staff did not utilize alcohol wipes to sanitize the catheter drainage bag tube after they emptied it. In addition, R44 stated staff do not always wash their hands between cares and stated, "I have huge concerns about infection control here." According to a Brief Interview for Mental Status	F 880	An infection prevention and control program has been implemented to surveillance and minimize and prevent the spread of infections. R44 and R58 are receiving appropriate care with the correct standard precautions as it relates to hand hygiene. R44 is receiving appropriate catheter care using the correct standard precautions technique. Medication rooms and medication carts have been cleaned and sanitized per standards of practice with a schedule implemented for routine cleaning. Resident and staff that reside and are employed at Galtier health center have the potential to be affected by this practice. DON/designee to ensure ongoing updates and follow up to the IPIC program. Hand sanitizers and soaps are made available to staff for appropriate hand hygiene during cares. Residents with Catheters received care plan reviews	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 (BIMS), R44 was assessed as cognitively intact on 4/21/18. During an observation on 6/6/17, at 7:01 a.m. nursing assistant (NA)-A entered R58's bedroom which was shared with R44, donned a pair of gloves, wet a washcloth in the bathroom sink and washed R58's face. NA-A proceded to wash under R58's breasts and the front perineal area. NA-A had R58 turned to the side, and NA-A washed R58's rectal area. While wearing the same gloves, NA-A applied a clean incontinent brief on R58, applied gripper socks to R58's feet, and dressed R58 with pants and a shirt. Without washing hands, or removing gloves, NA-A was observed to handle the remote control mechanism on the bed, touched the clothing in R58's closet, assisted R58 to sit up on the side of the bed, put R58's shoes on, and transfered R58 to the wheel chair. NA-A, then fingered through R58's hair in a brushing fashion. NA-A adjusted the brakes on the wheel chair and continued to open the bedside drawers looking for a hair brush, moving the trash can and replacing the trash can liner. NA-A then removed the gloves and left the room without using hand sanitizer, or washing hands. At 7:20 a.m. on 6/6/17, NA-A returned to the shared bedroom of R58 and R44 wearing gloves. NA-A had a trash bag of linens in her hands which NA-A set on the floor by the closed bedroom door. NA-A removed the gloves and discarded in the bathroom trash and donned another pair of gloves from the bathroom without hand hygiene. There were trash bags on a roll and NA-A removed a trash bag from the roll and placed it into the trash container. NA-A removed the gloves and left the room without hand	F 880	and are receiving appropriate catheter care. Medication rooms and medication carts will receive routine cleanings and sanitizing. Licensed nurses, nursing assistants, housekeeping, and facility leadership have been educated on IPIC program, hand hygiene, catheter care, and sanitary conditions related to medication room and medication carts. DON/designee will audit IPIC program, hand hygiene, catheter care, and sanitary conditions once weekly x 4 weeks, then 2 x monthly x 3 months. DON/Designee will forward results of the infection control program, practices and environmental audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 washing or sanitizing. At 7:24 a.m. on 6/6/17, NA-A returned to the room with a clean incontinence brief, transfer belt and wash cloths. NA-A was unable to go into the bathroom because someone from the adjoinning room was in the bathroom. NA-A left the room to obtain gloves, then returned to the room and picked up the trash bag from the floor that had been brought in from another area and placed that bag into the trash can, before donning a pair of gloves without hand washing or sanitizing. NA-A then began cares for R44. NA-A was observed to go into R44's closet to get clothing, and to obtain supplies from R44's dresser drawers. NA-A was observed to attempt to thread R44's catheter tubing and full urinary drainage bag through R44's pants. R44 directed NA-A to empty the urine from the bag first. At that time, NA-A went into the bathroom to obtain a graduate to drain the urine into. NA-A set the graduate on the floor without a barrier, drained the urine from the tubing, used a napkin to wipe drips of urine from the tip of the tubing, took the graduate to the bathroom and poured the urine into the toilet, rinsed the graduate with water from the sink, poured the water into the toilet, set the graduate container on the back of the toilet tank, and crumbled a paper towel which she put into the graduate container. NA-A then removed the gloves and donned another pair without any hand hygiene. NA-A wet multiple washcloths in the bathroom to be used for R44. One of the wet wash cloths fell on the floor and NA-A picked it up and placed it into the bag that was in the trash can. NA-A verified that particular trash bag contained contaminated linen. When asked where the bag of soiled linens came from, NA-A stated, "I should not have brought that in here."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41	F 880		

Then NA-A removed the gloves and left the room with the trash bag of dirty linen. NA-A returned to the bedroom reapplied gloves without hand hygiene, and proceeded to thread the catheter drainage bag and tubing through R44's pants. NA-A washed R44's buttocks and rectal area prior to reaching for a tube of peri guard. NA-A opened the peri guard and applied the ointment on R44's rectal area. NA-A then applied a brief, put on R44's pajama bottoms, removed a trash bag from a roll of bags sitting on the night stand, picked up R44's tennis shoes, adjusted R44's wheel chair to be closer to the bed, made the bed and adjusted the pillows, all without having removed the gloves, or performed hand hygiene. NA-A left the residents rooms with the gloves on, went down the hall to the dirty utility room, punched in a key code and disposed of the dirty linen and trash. At that time, NA-A finally removed the gloves, but still did not use hand sanitizer or wash her hands.

When interviewed on 6/6/18, at 7:55 a.m. NA-A was unable to state how long hands should be washed, but stated, "maybe for 5 seconds."

When interviewed on 6/6/18, at 8:00 a.m. licensed practical nurse (LPN)-A stated, "Hands should be washed for 60 seconds."

The facility policy Hand Hygiene Guidelines dated 11/28/17, included: "Rubbing hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers; rinsing hands with water and drying thoroughly with a disposable towel; and turning off the faucet on the hand sink with the disposable paper towel."

When interviewed on 6/6/18, at 8:44 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42	F 880		

registered nurse (RN)-A verified the facility expectation would be to follow the facility policy for handwashing, or alcohol gel use, whenever changing gloves.

The facility policy Perineal and Catheter Care dated 2015, included: "Emptying a urinary drainage bag. To begin, gather your supplies including a protective barrier, graduate, and an antiseptic wipe such as an alcohol pad. Be sure to provide privacy, perform hand hygiene, and apply gloves. Place the barrier on the floor underneath the drainage bag. Place the graduate on top of the barrier. Once the urine has drained, close the clamp and wipe the end of the drain tube or clamp with the antiseptic wipe to remove any residual urine. Cleanse the graduate according o your organization's policy and return to its storage location. Remove your gloves, discarded, and perform hand hygiene."

When interviewed on 6/6/18, at 8:44 a.m. RN-A verified staff were expected to follow the policy for perineal cleansing and catheter care.

During an observation of the third floor medication room on 6/6/18 at 8:14 a.m., LPN-B verified the two medication carts had multiple splatters of different colored substances, tan, brown, pink and black, throughout the drawers and outside of the carts. In addition, there were multiple pills on the bottoms of the medication drawers that had fallen out of the blister pack systems the facility utilizes, and cardboard and paper debris throughout the drawers. The third floor medication room floor was observed to be dirty and gritty with a heavy accumulation on the floor of sand and paper particles, as well as hair and grime. The counters and cubicles had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43	F 880		

heavy accumulation of gray matter, dust particles, debris present. The sink had a thick scum gray and tan substance accumulated all throughout the sink and faucet handles. The Formica on the side of the cupboard by the sink was water damaged, splintered, bubbling, crumbling and was not a cleanable surface.

During an observation of the second floor medication room on 6/5/18, at 10:33 a.m. LPN-C verified the two medication carts were soiled with multiple splatters of different colored substances throughout the drawers and the outsides of the carts. As on the third floor, the medication carts were noted to have pills in the bottoms of the medication drawers that had fallen out of the blister packs, and there was cardboard and paper debris throughout the drawers. The second floor medication room floor was also dirty and gritty with a heavy accumulation on the floor of sand and paper particles, as well as hair and grime. The counters and cubicles had a heavy accumulation of gray matter, dust particles, debris present. The sink had a thick scum gray and tan in color accumulated all throughout the sink and faucet handles. The cubicles had multiple layers of cellophane tape throughout the surface which was rolled and discolored from soiling. RN-J verified the tape on the cubicles was not a cleanable surface.

During an observation of the Medication room on the fourth floor on 6/5/18, at 10:48 a.m. LPN-D and LPN-E verified the medication cart was soiled. The cart had splatters of different colors, pills at the bottom of the medication drawers that had fallen out of the blister packs, and there were paper particles and small pieces of cardboard throughout the drawers of the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 44	F 880		

The fourth floor medication room floor was also dirty and gritty. The counters and cubicles had a heavy accumulation of gray matter, dust particles, debris present. The sink had a thick scum gray and tan in color accumulated all throughout the sink and faucet handles. During the observation, LPN-D and LPN-E verified the nurses are responsible to keep the medication carts clean but they did not know who was responsible for the deep cleaning of the medication carts or medication rooms.

The director of housekeeping (DH) reviewed the medication room and cart findings on the morning of 6/6/18. At 11:46 a.m., DH verified the house keeping department was responsible to clean the floors, counters and sinks in the medication rooms but stated nursing staff were supposed to let them know when it needed to be done. DH stated there was no specific policy and procedure for cleaning the medication carts and the medication rooms.

When Interviewed on 6/6/18, at 11:50 a.m. housekeeper (H)-A who works full time on the fourth floor verified the housekeeping staff are dependent upon the nursing staff to let them into the locked medication rooms. H-A stated, "Often it is difficult to get the nurse to open the doors. I typically just empty the trash and make sure there are paper towels available."

When interviewed on 6/6/18, at 11:55 a.m. H-B who works full time on the third floor verified the housekeeping staff were dependent on the nursing staff to let them into the locked medication room and stated, "Usually replacing paper towels and emptying the garbage is pretty much all that is done in the med rooms because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45 we have to get the nurses to open the door."	F 880		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary and orderly environment. This affect 2 residents (R38, R40) with unpainted walls, 8 residents with shared bathrooms (R6, R38, R40, R42, R43, R44, R57, R58), 5 residents (R38, R40, R43, R57, R3) with unkept privacy curtain, all residents and visitors on third and fourth floor who used the public water fountains and all residents who use the third floor storage room. Furthermore, the unclean elevator floor surfaces had the potential to affect all visitors and residents who used the elevators. Findings include: When interviewed on 6/4/18, at 2:00 p.m. R38 and R40 verified in their room that the east wall had a 5 foot by 5 foot area that had been scraped and patched and was missing a painted surface. According to R38 the wall area had been like that "for several weeks." The overhead privacy curtains were missing hooks, and one of the overhead privacy curtains had a large tear in the mesh section of the curtain. The bathroom had a black brown gray area around the toilet base that appeared to be an uncleanable surface on the grout and there was a stale odor that permeated	F 921	R38 and R40 have received a fresh coat of paint on their walls. R6, R38, R40, R42, R43, R44, R57, and R58 all received thorough bathroom cleanings to remove odor and clean the grout. R38, R40, R43, R57, and R3 received new privacy curtains. Water fountains on 3rd and 4th floor have been fixed and cleaned. 3rd floor storage room has been cleaned and flooring replaced. The elevator floor is also in TELS to be replaced with a cleanable surface. Shared bathrooms for rooms 306 and 311 have been deep cleaned and disinfected. Residents, staff and visitors that resident and/or visit Galtier Health Center have the potential to be affected by this practice. A system has been put into place to ensure routine monitoring and cleaning in place to avoid future conditions. Housekeeping, Administrator, maintenance, and nursing services have been educated on safe, sanitary, and comfortable environment. All have been educated on new system for monitoring and communicating unsatisfactory conditions as well as validating corrections.	7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 46 the bathroom. During an observation on 6/4/18, at 4:00 p.m. R44 and R58 pointed to the ceiling area running the extent of the bedroom that appeared dark brown and black in color against the white ceiling that did not appear clean. R44 expressed concern that the bathroom was not clean and sometimes there was an odor "like old urine" in the bathroom. The toilet base grout had a black brown grime build up and there was a strong odor of urine detected. R44 expressed the bathroom is shared by 4 residents (R6, R42) and according to R44 the bathroom is "not cleaned very well every day. " During an interview on 6/4/18, at 6:00 p.m. R43 expressed concern about seeing bugs in the bedroom and bathroom and that the bathroom was not clean. Observation of the bathroom revealed the grout around the base of the toilet tank was black and brown in areas and the floor was separating from the grout area. The bedroom privacy curtains were missing hooks and the privacy curtain was stained with large gray splatters. R57 was R43's roommate and verified the findings. During observation throughout various dates and times upon entering the facility 6/4/18, the public water fountain on third and fourth floor had a reddish brown substance appearing around the drain as well as a heavy accumulation of white lime like substance on the spigot of the water fountain. During observation upon entrance to the facility on 6/4/18, at 11:30 a.m. and throughout various times in the facility, the small and large elevators	F 921	Administrator/designee will audit environment, cleanliness, and facilities daily x 2 weeks then 3 times weekly x 3 months. Administrator/Designee will forward results of the environmental tour audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. Date of compliance 7/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 47	F 921		

had multiple tears and gouges in the flooring that prevented the surface from being cleanable as bare wood was exposed in multiple areas. When interviewed on 6/7/18, at 2:00 p.m. the administrator was aware of the issue with the flooring, but the company was still formulating capital expenditures that would need to be approved by the corporation.

During environmental rounds with the environmental director (ED) on 6/7/18, at 8:56 a.m. verified the above findings that the facility needed a system to finish painting rooms, to go around and check the privacy curtains, and the grout replacement around toilet bases needed to be evaluated. Furthermore, the maintenance director verified the public water fountain drains needed to be replaced and the faucet parts needed to be de-limed. The ED verified there was not a facility policy on these issues but when staff noted the issues they should be documented on the request form located at each nursing desk. The ED verified the facility did not have a routine system to check for room painting, privacy curtains, toilet grout, water fountains, and relied on the housekeepers and nursing staff to report issues.

06/04/18, 01:26 PM the privacy curtains mesh in the middle is torn with a large hole, curtain hooks missing and loose and difficult to pull on the curtain on the track and hooks loose as well and resident stated that is been more than five months and told the housekeeping manager and they did not do anything about it.

On 6/6/18, at 10:13 a.m., the privacy curtains still remain torn and have loose tracks and difficult to pull and observed licensed practical nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 48	F 921		

(LPN)-F having difficult time pulling the privacy curtain to give resident privacy. LPN-F and LPN-D verified the finding and LPN-F indicated, "I will tell [housekeeping director] from house keeping to come take a look at it."

On 6/6/18, at 10:33 a.m., housekeeping (HK-A) verified that privacy curtain in the middle had a large torn and the one by the foot of the bed had multiple areas that the hooks are off and some hooks are holding the curtain are missing as well. HK-A stated, "I am new here just started working here I transferred from another facility".

On 6/6/18, at 10:39 a.m., Housekeeping Director (HD) verified the privacy curtain in the middle had large tears and the one by the foot of the bed had multiple areas that the curtain hooks were off the curtain mesh and some curtain hooks that were holding the curtain were missing as well. HD stated, his expectation is that curtain mesh should be replace when torn and that the curtain hooks should be holding the curtain in place. He stated he was going to do the curtain audits on this floor today and will make sure those are taken care of. He continued by explaining, normally the torn curtains are removed and replace with new ones. I am going to ask the maintenance director (MD-G) to order new ones for the resident.

The policy and procedure titled CLEANING CUBICLE CURTAINS, dated 6/2016, read, "Examine curtains while doing QCI or at discharge... If curtain is torn - replace. If curtains are off hooks. repair... Have additional hooks available for repair. Have spare curtains on hand to immediately replace dirty or torn curtains..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 49 During a random observation on 6/7/18, at 10:15 a.m., surveyor observed the storage room on 3rd floor by the nursing station while a resident was getting ice. This surveyor noted that the resident weight scale was in the room and the carpet had multiple black spots, large areas of red stained spots, paper crumbs and ice buckets were in the room. During an interview with (LPN)-J on 6/7/18, at 1:31 p.m., stated that staff normally weigh resident in the storage room and the weight scale is kept in there. During an interview with (LPN)-A on 6/7/18, at 1:36 p.m., stated that staff normally weigh residents in the storage room and the weight scale and ice bucket are normally kept in this room. LPN-A added that the storage room is always filthy and has been for months; stating the Administrator was informed nothing has been done yet. During an interview with the administrator on 6/7/18, at 12:41 p.m., observation of the 3rd floor storage room was verified. The admin stated she spoke with MD-G regarding carpet condition in the 3rd floor storage and there is a plan in place to replace the carpet. Also, the maintenance staff is on work restriction and have to wait until regional maintenance director comes back to work for them to complete task together. No date is set yet. No work order was available for review.	F 921		

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 _____	**06/05/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Galtier Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/05/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St Paul, MN 55101-5145, 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 and built in 1963. It has a full basement and is fully fire sprinklered. The facility has a capacity of 107 beds. At the time of the survey the census was 82.	K 000		
K 363 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		6/29/18

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 _____	**06/05/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 2 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485) This deficient practice could affect the safety of all (19) the residents, staff and visitors within the smoke compartment.	K 363	The smoke compartment door was adjusted and shuts properly. Compliance achieved 6/13/18. Maintenance will check all fire doors monthly.	

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 _____	**06/05/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 3 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 6/5/2018, observations and staff interview revealed the following: Found the smoke compartment door on 3rd floor by room 313 would not close when tested. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245340	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**6/5/2018**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 930	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (11.7.2 through 11.7.4 (NFPA 99).) This deficient practice could affect the safety of all the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 6/5/2018, observations and staff interview revealed the following: The storage and use of liquid oxygen in base reservoir containers are being used in resident rooms. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

Electronically delivered
June 22, 2018

Ms. Catherine Scoville, Administrator
Galtier A Villa Center
445 Galtier Avenue
Saint Paul, MN 55103

Re: State Nursing Home Licensing Orders - Project Number S5340027

Dear Ms. Scoville:

The above facility was surveyed on June 4, 2018 through June 7, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susie Haben, Unit Supervisor at (651) 201-3794 or susie.haben@state.mn.us.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	00480	A. BUILDING: _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 4,5,6 and 7, 2018 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 3 Based on interview and record review, the facility failed to provide a description of facility staff training for the care of residents with dementia/Alzheimer's, in written or electronic format to consumers. Findings Include: On 6/7/18, at 2:30 p.m., the administrator stated the facility did not have written information available for consumer's related to dementia/Alzheimer's training provided to staff. The facility's admission packet, provided to residents at admission was reviewed. There was no information found related to training for staff on dementia/Alzheimer's. The administrator verified this information. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement dementia care training and ensure all direct care staff and their supervisors, including any new employees receive the required training. The facility could create a document describing their staff training program, categories of employees trained and the frequency of the training, as required to provide to consumers. The administrator or designee could develop an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 302	As of 2017, communication of staff Alzheimer's disease training was provided within the survey binder at the entrance of Galtier for residents and family. Within the statue, it states that the information on staff dementia training must be given to every resident/family member. Staff training on Alzheimer's disease includes but is not limited to Causes of behavior problems and Psychosocial Needs. Galtier has moved this document to the admission packet. It will be provided to all residents/family at admission. In service training will be provided on 6/28, 6/29 and 7/2 for all shifts. Training will be provided to all staff during in service and additional annual training through Relias on line learning system. Activity Director will communicate during resident council that all staff are trained for dementia disease. Administrator/designee to monitor. Audits of new admissions weekly x 4 quarterly thereafter. Audits results will be brought to monthly QA. Administrator/designee to monitor.	
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	2 555		7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 4 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 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 observation, interview and document review, the facility failed to ensure care conferences were held after each assessment, and failed to include the resident in the care planning process for 2 of 3 residents (R43 and R52) reviewed for care planning. Findings include: When interviewed on 6/5/18, at 8:26 a.m. R43 expressed concern about staff being aware of preferences for care, and awareness of her food allergies. When asked about the plan of care and participation in the plan of care, R43 stated, "I have never seen my plan of care, and I can't remember meeting about my plan of care." R43's cognitive assessment dated 4/18/18, indicated R43 had mild cognitive impairment. When interviewed on 6/6/18, at 8:44 a.m. registered nurse (RN)-A and the social service designee (SSD) verified they were not aware of R43's concerns. When asked about her participation in care conferences, RN-A and SSD	2 555	Corrected.	

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 5 discovered R43's last care conference had been held on 1/26/18, and stated R43 and her family had attended. RN-A and SSD stated R43's quarterly care conference had been missed in April/May, and stated they had been waiting to hear from R43's family about when they could attend. When interviewed on 6/4/18, at 1:00 p.m. R52 stated, "I am very upset about my weight gain and the facility will not help me, and won't even give me a salad, today is a perfect example because I asked for a salad at lunch time and was told they did not have any salad." When interviewed on 6/6/18 at 9:25 a.m. RN-A and SSD verified the last care conference held for R52 was documented as 2/27/18. They also confirmed the dietitian had not been in attendance. They stated R52's quarterly care conference due for the end of May was overdue, but would be scheduled soon. R52's weights were reviewed. An admission weight was documented on 4/30/17 to be 135 pounds. R52's current weight was documented as 161 pounds. According to care conference notes, the last quarterly care conference had been held on 2/27/18, with the resident and guardian present. On 3/7/18, the dietitian documented in the Nutritional Monitoring and Evaluation section of the chart, "current weight 150 # is 111% IWR (ideal weight range); planned weight gain since November weight of 119#, increase 30# /180 days from 120#(25%). Although weight increase to slightly above healthy range, res (resident) benefits from gain with adequate intake. Nutritious Juice d/c (discontinued) 3/5 (3/5/18) 2/2	2 555		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 6 (secondary to) gain... po (oral) intake range from 75-100% of meals providing 1700-2200 cal/meals (calories from meals) plus HS (hour of sleep) snack...needs increased slightly 2/2 weight gain...Continue POC (plan of care). There was no documentation to indicate the dietitian had discussed R52's weight gain or the risks and benefits associated with the weight gain with the resident at the time of the care conference, or since. When interviewed on 6/6/18, at 9:41 a.m. the registered dietitian (RD) stated she was new to the facility, and had worked there about four weeks. The RD reviewed the documented assessments from the previous RD, and verified a dietitian had not met with the resident. The RD verified the resident should have been involved with the nutritional plan and stated she would meet with the resident as soon as possible. A policy was requested regarding the scheduling of care conference's but none was provided by the time of the exit. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement a person centered plan of care procedure; centered around the resident. Ensuring the resident is the driving force in decision making when possible and when the desire to participate is communicated. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 555		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 7	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to protect the skin and prevent further breakdown of a facility acquired pressure ulcer for 1 of 3 residents (R65) reviewed for pressure ulcers. The failure of the facility to consistently implement ordered interventions, and reassess the effectiveness of the interventions in a timely manner, resulted in the deterioration of a facility acquired pressure ulcer from a stage II to an unstageable ulcer, which resulted in harm for R65. Findings include: On 6/4/18, at 1:43 p.m. R65 was observed laying in bed. R65 was positioned on his back, and	2 900	Corrected.	7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8	2 900		

covered by a sheet. Under the sheet, R65 had positioned both heels pulled up towards the buttocks, so his knees were bent and in the air as he appeared to be digging both heels into the mattress. There was a light blue structured walking boot with Velcro straps on the bedside table, and another style of unstructured boot that was smaller, soft, and dark blue, in the corner of the bed on top of the sheet. When questioned what the boots were used for, R65 was confused, asking what boots? After pointing to the boots on the bedside table and bed, R65 was unable to state when they were used, and said they were worn in the winter to help with the cold.

During observation on 6/5/18, at 9:32 a.m. R65 was asleep in bed. Again, R65 was positioned laying on his back, with both heels pulled up toward his buttocks, with his knees in the air. R65's heels were pressed into the mattress on the bed, and he had a thin sheet pulled up over himself. R65 did not appear to have boots on either foot, as the outline of the foot and toes could be seen under the sheet. The structured light blue boot was observed on the bedside table.

During observation on 6/5/18, at 3:56 p.m. R65 was observed lying in bed under a thin, white knit blanket. R65 was not wearing shoes or boots as the outline of the foot and toes could be seen under the knit blanket. R65 was supine, laying flat on the back, with legs straight and both heels resting on the mattress.

During interview on 6/5/18, at 4:23 p.m., registered nurse (RN)-D did not believe R65 had any current skin concerns, but wanted to check the eMR (electronic medical record) to be sure. RN-D said R65 had only been living on the unit

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9 for about 2-3 weeks. RN-D looked in the eMR and reported that R65 had a history of a closed buttock ulcer, a left heel ulcer, and orders to reposition the resident every two hours. On 6/6/18, at 7:06 a.m., R65 was observed sitting up in a wheelchair in his room with socks on both feet which were resting on the footrests. At 7:08 a.m. R65 propelled himself in the wheelchair into the hallway. He used both arms to slowly move the wheels little by little, and also moved his feet off the foot pedals, pulling the chair along by digging his heels into the floor and pulling. At that time, licensed practical nurse (LPN)-K greeted R65 and stated, "Let's get your boots on." LPN-K stated to nearby staff, "[R65] needs to wear [his/her] boots all the time." At 7:10 a.m. R65 again propelled self out of the room in the wheelchair. R65 was now wearing the soft, dark blue boots on both feet. The boots covered the heels and sides of the feet, and did not appear to have any firm support, but rather offered a soft, comfort type cushion. The entire top of the boot was open, exposing the top of the foot, except for a single strap over the foot near the ankle. R65 was observed to wander the hallway in the wheelchair until 7:20 a.m. when staff offered to push R65 to the dining room for breakfast. At 7:47 a.m. R65 moved around the dining room in the wheelchair using his feet to dig into the floor to pull himself, using his arms to push the wheels a little at a time. The soft left boot was observed to have slid off R65's heel and was twisted sideways. After breakfast at 8:58 a.m. on 6/6/18, R65 was observed propelling himself back to his room. The left boot was still twisted and was observed to be sliding off the foot, leaving the left heel unprotected. At 9:01 a.m. staff entered R65's	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 10	2 900		

room and removed the boots prior to transferring R65 to the toilet. At 9:09 a.m. staff put the soft boots back on R65's feet before leaving R65 in the wheelchair to watch a movie in the room, per the resident's request.

During interview on 6/6/18, at 10:06 a.m. the director of nursing (DON) discussed the measurements of the left heel pressure ulcer. The DON explained that a nurse assessed the wound weekly, and that it could be a nurse manager or a nurse on duty. After assessing, the nurse input the description and measurements, along with pictures of the wound, in the electronic wound tracking system. The DON pulled up current treatments in the electronic wound tracking system and it was noted all current treatments had been initiated on 2/23/18: a high calorie supplement, leaving the wound open to air, keeping heels off the bed, using an ointment, and a low air loss mattress. The DON stated she did not see current treatments for the right wound, but thought the treatment should be the same as the left. The DON reviewed the weekly measurements and said the left heel wound had almost closed in April, but had then started scabbing again. The DON confirmed the most recent wound measurements were from 6/4/18, and measured 10.0 centimeters (cm) x 6.0 cm, which was larger than prior measurements (3.5 cm x 3.0 cm on 6/1/18, 2.0 cm x 2.0 cm on 5/7/18). The DON stated she was concerned about the accuracy of how nursing staff measured the wound. In the pictures, staff held up a flexible ruler next to the skin opening to show the wound size, some staff appeared to measure straight across the wound, while others wrapped the ruler around the ankle to measure. The DON stated she was concerned about the large jump in documented measurements from

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 11 6/1/18 (3.5 cm x 3.0 cm) to 6/4/18 (10.0 cm x 6.0 cm), and would ask nursing staff to re-measure the left heel wound to confirm size. On 6/6/18 at 10:35 a.m., R65 was observed to be supine in bed. The covers were turned down, so R65's legs and feet were visible. R65 was not wearing boots, had a sock on the right foot, but nothing on the left foot. R65's heels rested on the bed. The light blue structured boot was missing from the bedside table, and the soft, dark blue boots were on the floor. LPN-K and LPN-D entered the room and prepared to assess and re-measure the left heel. At 10:38 a.m. LPN-K asked LPN-D why the dark blue boots were on the floor and stated, "[R65] needs to wear them at all times." LPN-D did not know why the boots were on the floor, but stated R65 sometimes removed them. The bandage on the left heel was balled up and starting to fall off. LPN-D removed the bandage, and washed the wound. There was a large, dry flap of skin still partially attached on one side, and above the flap was a dark purple/black scab type area. At 10:41 a.m., LPN-D measured the the entire area as 7.0 cm x 5.0 cm, and measured the dark area as 4.5 cm x 2.5 cm. LPN-K stated the wound was categorized as unstageable, because there was no way to know how deep the wound went underneath the dark, scabby tissue. LPN-D applied an adhesive foam dressing to the wound, before getting clean socks for R65, as the wound drainage had left rusty, brown spots on the inside of the sock. Review of the R65's admission record documentation revealed R65 was admitted to the facility on 1/30/18, with diagnoses including: Alzheimer's disease, generalized muscle weakness, and peripheral vascular disease. During the most recent quarterly Minimum Data	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 12 Set (MDS) assessment dated 5/7/18, staff had assessed R65 to be severely cognitively impaired, with a brief interview for mental status (BIMS) score of 3 (indicating severe cognitive impairment). The care area assessment for the most recent annual MDS dated 2/6/18, indicated R65 was at risk for pressure injury due to dependence on staff for activities of daily living, mood/behaviors, and pain. In addition, R65 was assessed to be reluctant to move or change position due to pain, and staff were to provide off loading and repositioning to prevent pressure. Further the assessment indicated licensed staff were to observe for indications of pressure or skin breakdown. Review of the wound record in the electronic medical record (eMR) revealed R65 currently had two pressure ulcers; one on each heel. The right heel blister was currently categorized as unstageable, was acquired in the facility, and was identified on 5/22/18. The left heel blister was currently categorized as unstageable, also acquired in the facility, and was identified on 2/20/18. Pressure Ulcer Documentation Guidelines provided by the facility, and written by the National Pressure Ulcer Advisory Panel, described an unstageable pressure ulcer as being a wound with full thickness tissue loss in which the base of the ulcer is covered by slough (devitalized tissue that is yellow, tan, gray, green or brown) and/or Eschar (dead tissue that is tan, brown or black) in the wound bed. Until the slough/eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. On 6/6/18 at 11:40 a.m., copies of the current nursing assistant care guide was requested. At 3:28 p.m. the DON provided an undated copy of	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 13	2 900		

the nursing assistant care guide, which directed nursing assistants to ensure R65 wore Spenco boots on both feet. Under the special requirements section, there was guidance for R65 to wear Spenco boots at all times to protect R65's heels, and that R65 was being fitted for PRAFO boots (custom fitted supportive boots that keep all pressure off heels). The guidance also indicated staff were to provide wound treatments for the heels, and were to turn and reposition R65 every 2-3 hours while in bed.

A progress note written on 6/6/18, at 1:13 p.m. included: "[Nurse Practitioner] updated and this writer received orders for PRAFO boots to be ordered; will be here at 3 PM to fit [R65] for the boots today".

On 6/7/18, at 7:45 a.m. R65 was observed sleeping in bed under a sheet. R65 was laying on his back, and there appeared to be a pillow under R65's knees, because both knees were bent and slightly elevated. The two soft, dark blue boots were observed on the floor next to the bed, and next to them sat a new pair of PRAFO boots. R65 was not observed to be wearing boots as both heels rested on the mattress.

On 6/7/18, at 7:51 a.m., LPN-D stated R65 was supposed to be wearing the soft, dark blue boots when R65 was up, and that they should also be on when R65 was in bed. LPN-D also stated R65 did not like to wear the boots, but that they should be on in bed because R65 always dragged both heels against the mattress in bed, which could cause pressure. LPN-D looked in the room at R65, and confirmed R65 was not currently wearing any protective boots. At 8:02 a.m. nursing assistant (NA)-C stated, "[R65] has little booties which [R65] is supposed to wear pretty

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14 much all the time." NA-C said this was not a new intervention, but mentioned that R65 was newer to this unit. On 6/7/18, at 8:22 a.m. the DON confirmed R65 got PRAFO boots fitted yesterday. The DON described how R65 liked to take his/her feet off the foot pedals when seated in the wheelchair, and rest heels on the floor, pulling his/her bodyweight along in the wheelchair using the heels. The DON said this was how R65 propelled himself around the unit. The DON said the soft, little dark blue boots would twist and come off while R65 moved around the unit in this manner, but the new PRAFO boots were less likely to fall off. The DON said there was a new order created yesterday, which required R65 to wear the PRAFO boots at all times. Before the PRAFO boots, the order was for R65 to wear the Spenco boots at all times, although the DON said R65 did not always like to wear them. The DON explained that when it came to special order footwear, such as the PRAFO boots, therapy first assessed what was appropriate, and then the physician got involved to approve ordering the special footwear. When asked why the PRAFO boots were just ordered yesterday, the DON replied that when the size of the wound recently got bigger, staff looked at the interventions currently in place, and determined that the interventions obviously were not working. Again the DON described how the soft little boots staff were putting on R65 would not stay in place, and would twist around on R65's feet because the resident was very active and self propelled the wheelchair using the feet. On 6/7/18, at 8:30 a.m. R65 was observed with the new PRAFO boots on, which had a hard plastic piece that curved around and away from the heel, providing space between the heel and	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 15 the boot to protect the heel from pressure, and ensure the heels were floated off the bed. In a follow-up interview on 6/7/18, at 8:37 a.m. the DON was asked why some of the nursing staff did not seem to be aware of R65's pressure ulcers when asked if R65 had any skin concerns. The DON said R65 had moved onto the unit from another floor on 5/7/18, but explained that all the regular staff on the floor should know about R65's heel ulcers. The DON said that even if staff floated on the unit to fill in, and did not typically work on the unit, the details of R65's care were written on the nursing assistant care guide, so all staff should know what R65 needed. The DON again reviewed the left heel ulcer measurements, and noted that the increase in size had occurred after R65 moved onto the new unit. The DON wondered out loud if the new staff needed time to adjust to R65's cares, and get to know R65 after the move. The DON said that the left heel wound previously looked like it was getting better, but had then gotten bigger. The DON questioned whether there was a communication issue, which could be why staff were not all aware of what was supposed to be happening to protect R65's heels. During interview on 6/7/18, at 10:37 a.m. the physical therapy assistant (PTA) confirmed meeting with R65 the day before at the request of nursing staff. PTA said nursing called, and described the manner in which R65 dug both heels into the ground to pull self along in the wheelchair. PTA remembered working with R65 earlier that winter, and confirmed that R65 was in a wheelchair at that time too, and also self propelled in the chair by using a combination of arms and feet. After being called by nursing yesterday, PTA quickly took a look at R65 before contacting the orthotic company to request fitting	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 16 R65 with PRAFO boots. PTA said the orthotics company was able to come out quickly to the facility yesterday afternoon to fit R65 with the boots. During interview on 6/7/18, at 11:05 a.m. the administrator provided a new nursing assistant care guide, and explained that it had been updated today. The updated care guide included R65's need to wear PRAFO boots at all times on both feet to protect and float the heels, and to encourage R65 to keep boots on. The guide was also updated with the requirement that R65 be turned and repositioned every 20 minutes while in bed. During interview on 6/7/18, at 12:14 p.m., the registered dietitian (RD) described having a conversation with the unit manager about R65. RD explained being made aware of the skin breakdown yesterday, and as a result, added Pure Protein (protein shake) and Juven (nutrition powder for wound healing) to R65's diet. RD explained R65 was previously taking a high calorie supplement which had some protein, but not as much as what R65 currently needed; hence adding Pure Protein and Juven. RD explained how the nutritional supplements needed by any resident really depended on factors such as a resident's body size, and what was going on with a wound. RD said that R65 needed the extra nutritional supplements added, as R65's needs had increased drastically with the wound breakdown. A progress note written on 6/6/18, at 3:20 p.m., indicated "RD followed up with [unit manager] regarding resident's unstageable [pressure ulcer]. Per [unit manager], resident with history of pressure ulcers and had a stage II [pressure	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 17	2 900		

ulcer] on heel. Resident uses [his/her] heels to pull [his/her] wheelchair and resident drags [his/her] heel against the mattress when in bed. [Unit manager] feels this is what caused resident's heels to open. RD will continue to follow."

Review of pertinent orders revealed the following:
-2/26/18. Left heel blister measuring 4.5 centimeters (cm) x 4.0 cm noted on 2/20/18. Keep clean and dry, monitor for signs and symptoms of infection, or further signs and symptoms of breakdown. Spenco boots on both feet at all times, keep heels off the bed.
- 2/26/18. 120 cubic centimeters (cc) of Hi-Cal (high calorie supplement) three times a day.
-2/26/18. Apply Vitamin A and D ointment to both feet and legs twice daily.
- 2/26/18. Turn and position resident every 2 hours and as needed.
-5/22/18. Order for off load boots for "2/2 heel blisters; therapy updated."
-6/6/18. PRAFO boots to be worn at all times to make sure that heels remain offloaded.
- 6/6/18. Left heel ulcer: monitor for signs and symptoms of infection, or further signs and symptoms of breakdown. Bilateral float boots on at all times, keep heels off the bed.
- 6/6/18. One packet of Juven two times a day for wound healing.
- 6/6/18. 60 cc Prostat Sugar Free AWC (advanced wound care) nutritional supplement two times a day for wound healing.

On 6/5/18, review of the current care plan in the eMR confirmed R65 had the potential for a pressure ulcers related to dermal (skin) frailty, decreased mobility, inadequate nutrition, and dehydration. The care plan described R65 as having history of prior pressure ulcers that had

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 18 scabbed over and closed. The care plan noted the fluid filled blister to the left heel on 2/20/18. The care plan did not mention the pressure ulcer on the right heel. Interventions included administering treatments as ordered and monitoring for effectiveness. The care plan directed staff to avoid positioning R65 on the left heel, and to keep heels off the bed at all times with bilateral Spenco boots. Additionally, the care plan required staff to monitor the dressing each shift to ensure it was intact and adhering, and assess and record wound healing weekly, by measuring length, width, and depth where possible. Staff were to report improvement and declines to the Medical Doctor. On 6/6/18 at 11:40 a.m. a copy of the care plan was requested. A portion of the care plan was provided, but failed to include the section about pressure ulcers, so unable to determine when the care plan had been last updated at the time of review on 6/5/18. The most recent physician progress note in the chart at the time of review on 6/7/18, was for an encounter dated 4/12/18. The note had the following written about pressure ulcers: "Left heel wound. [Continue] local cares, use Spenco boots." The most recent nurse practitioner progress note in the chart was for an encounter on 3/23/18, and did not mention anything regarding pressure ulcers. The physician progress note from a 3/15/18 encounter did not mention anything regarding pressure ulcers. The nurse practitioner progress note from a 3/8/18 encounter noted, "Left heel dry skin with old blood under from previous blister," and "Continue to protect and relieve pressure." The facility utilized WoundRounds, a computer module for monitoring wounds. The module	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 19 included a Pressure Ulcer Scale for healing (PUSH) score which, according to the National Pressure Ulcer Advisory Panel, is a scoring system that helps compare the improvement (decreasing PUSH numbers) or deterioration (increasing PUSH numbers) of a wound. The PUSH number was calculated each time the wound was assessed, using data collected such as the wound size, drainage amount, and tissue types. Review of the weekly wound monitoring revealed the following history of the right heel pressure ulcer: -5/22/18: Clinical stage: unstageable (full thickness tissue loss in which the base of the ulcer is covered so the true depth can not be determined.) Tissue type: 100% intact skin. 7.0 cm x 4.0 cm, depth unknown. No drainage. PUSH 11. -6/1/18: Clinical stage: Unstageable. Tissue type: 25% bright pink or red. 6.5 cm x 3.5 cm, depth unknown. No drainage. PUSH 11. -6/4/18: Clinical stage: Unstageable. Tissue type: 100% slough (yellow, devitalized tissue) loosely adherent. 6.5 cm x 3.5 cm, depth unknown. No drainage. PUSH 12. Review of weekly wound monitoring revealed the following history of the left heel pressure ulcer: -2/23/18: Clinical stage: Stage II (Partial thickness loss of dermis). Tissue type: 100% blood filled blister. 4.5 cm x 4.2 cm, with no depth. Moderate serosanguineous drainage (contains serum and blood). PUSH 12. -2/26/18: Clinical stage: Stage II. Tissue type: 100% blood filled blister. 3.5 cm x 4.0 cm, with no depth. Moderate serosanguineous drainage. PUSH 12. -3/5/18: Clinical stage: Stage II. Tissue type:	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 20 100% blood filled blister. 3.5 cm x 3.5 cm, with no depth. Moderate serosanguineous drainage. PUSH 12. -3/12/18: Clinical stage: Stage II. Tissue type: 100% blood filled blister. 3.5 cm x 3.5 cm, with no depth. Moderate serosanguineous drainage. PUSH 12. -3/22/18: Clinical stage: Stage II. Tissue type: 50% purple ecchymosis (subcutaneous bleeding), 50% slough loosely adherent. 4.0 cm x 3.5 cm, with no depth. Light serosanguineous drainage. PUSH 13. -3/27/18: Clinical stage: Stage II. Tissue type: % purple ecchymosis (subcutaneous bleeding), 50% slough loosely adherent. 4.0 cm x 3.5 cm, with no depth. Light serosanguineous drainage. PUSH 13. -4/2/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red (often indicative of healthy, healing tissue), 50% slough loosely adherent. 4.0 cm x 3.5 cm, with no depth. Light serosanguineous drainage. PUSH 13. - 4/10/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 4.0 cm x 3.5 cm, with no depth. No drainage. PUSH 12. -4/16/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 2.0 cm x 3.0 cm, with no depth. No drainage. PUSH 10. -4/23/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 2.0 cm x 3.0 cm, with no depth. No drainage. PUSH 10. -5/2/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50% slough loosely adherent. 2.0 cm x 3.0 cm, with no depth. No drainage. PUSH 10 -5/7/18: Clinical stage: Stage II. Tissue type: 20% purple ecchymosis, 30% bright beefy red, 50%	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 21 slough loosely adherent. 2.0 cm x 2.0 cm, with no depth. No drainage. PUSH 9. -5/16/18: Clinical stage: Unstageable. Tissue type: 45% blood filled blister, 55% purple ecchymosis. 4.0 cm x 5.0 cm, depth unknown. No drainage. PUSH 10. -5/22/18: Clinical stage: Unstageable. Tissue type: 65% deep maroon, 35% slough loosely adherent. 3.5 cm x 3.0 cm, depth unknown. No drainage. PUSH 11. -6/1/18: Clinical stage: Unstageable. Tissue type: 65% deep maroon, 35% slough loosely adherent. 3.5 cm x 3.0 cm, depth unknown. No drainage. PUSH 11. -6/4/18: Clinical stage: Unstageable. Tissue type: 55% slough non-adherent, 45% necrotic (dead) hard adherent. 10.0 cm x 6.0 cm, depth unknown. Moderate serosanguineous drainage. PUSH 16. -6/6/18: Clinical stage: Unstageable. Tissue type: 50% deep maroon, 50% slough loosely adherent. 7.0 cm x 5.0 cm, depth unknown. Moderate serosanguineous drainage. PUSH 15. The Skin Management Guideline, effective 11/28/17, had the following purpose: "To ensure residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown." Additionally, per the guideline, a complete, comprehensive evaluation guides the identification of residents at risk, and factors predicting the risk for breakdown; identification of interventions to stabilize, reduce or remove underlying risk factors; evaluate the effectiveness of interventions; modify the interventions as appropriate. The dietitian will be notified upon discovery of a wound, when a wound declines unexpectedly, and if a wound is	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 22 not showing progress in 2-4 weeks. A therapy evaluation will be requested for positioning and treatment as appropriate upon admission and with a change in condition. Evaluate interventions per risk factors identified and re-evaluate and modify the plan of care based on root cause analysis for new skin alterations. Consult with a physician/nurse practitioner, family and supervisor/designee if the ulcer(s) has not shown progress in two weeks. Consult with the physician/nurse practitioner if the wound is deteriorating or increases in size. Re-evaluate plan of care as appropriate. Post survey, on 6/9/18, at 9:31 a.m. the administrator forwarded information by email that had not been provided during survey. The documentation provided post survey indicated the interdisciplinary team had reviewed R65's status and had updated the resident's care plan to include: 1. Therapy recommended Prafo boots on at all times 2. Interventions were placed in the [point of care] Task list to monitor resident self-removal/displacement of the brace. 3. An air mattress was ordered. 4. Care delivery guides updated to reflect the changes. In addition, the email indicated the interdisciplinary team had completed an action plan on 6/7/18, regarding proper assessment and staging of pressure ulcers, including education with proper positioning, placement, and pictures utilized for WoundRounds. The information provided did not diminish the facility's responsiblity to ensure interventions prescribed should have been implemented, and did not diminish the fact the resident's heel ulcer had increased from a Stage II to an unstageable ulcer. SUGGESTED METHOD OF CORRECTION:	2 900		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 23 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. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 900		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate 2 of 2 residents' (R52, R14) preferences for food choices. This had the potential to affect all 83 residents who received meals provided by the facility. Findings include:	2 965	Corrected.	7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 24 During an observation of the third floor dining room on 6/4/18, at 12:00 p.m. R52 stated, "I don't want the pork and they took away our alternates last week without telling us why." Review of the posted menu, located on a bulletin board in the dining room, verified pork was being served for lunch. No alternate choice was listed. When interviewed on 6/4/18, at 12:10 p.m. dietary aide (DA)-A stated, "There is no alternate, they took those away last week." DA-A verified alternative meal options were no longer available, and stated no explanation had been provided by management. On 6/4/18 at 5:28 p.m., R14 stated, "Rresidents had an alternative food option before but have not since this new company took over. I call my daughter to bring food for me, if I don't like what they serve. You cannot even call downstairs for a sandwich, it's bad". During the evening meal on second floor on 6/4/18 at 5:54 p.m., DA-B was interviewed about whether there was an alternate meal if a resident wouldn't want what was being served. DA-B stated the facility no longer had alternate meals. During an observation of the third floor dining room on the evening of 6/4/18, at 6:15 p.m. multiple residents were heard discussing how upset they were regarding the removal of alternative meal option. Review of the posted menu on the bulletin board in the dining room indicated tacos were being served for dinner. No alternate choice was listed. When interviewed on 6/4/18, at 6:20 p.m. DA-B stated, "They stopped offering alternatives a	2 965		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 25 week ago and no one told us [employees or residents] why." When interviewed on 6/5/18, at 8:30 a.m. registered nurse (RN)-A and the social service designee (SSD) verified there were no longer alternate meal options being provided since "last week". They said they thought it had something to do with the new management but stated they had not been involved in the discussion, or planning process. RN-A said she'd reported to the dietary manager already last week, that residents were complaining about having the alternate food choices taken away. During an interview on 6/5/18, at 11:54 a.m. the facility's regional culinary director confirmed there had been no alternate meal options the day before, but said she was unaware of the issue until later. She stated, "There should always be an alternate meal option for residents to choose from. The goal is for the facility to move to a menu with one chef special of the day, in addition to a menu with items that are always available for residents to choose from." A policy regarding alternate food choices was requested but not received at the time of the exit conference. SUGGESTED METHOD OF CORRECTION: The registered dietitian or designee could develop policies and procedures related to ensuring residents who request an alternate meal receive a meal of equal nutritive value. The registered dietitian or designee could educate staff regarding these polices, and audit resident records for compliance to these policies and procedures.	2 965		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement infection control practices to minimize and prevent the spread of infections. Staff failed to appropriately implement hand hygiene during personal care for 2 of 5 residents (R44 and R58); failed to utilize sanitary technique for emptying a urinary drainage bag for 1 of 1resident (R44) observed for catheter care; failed to maintain sanitary conditions for 3 of 3 medication rooms; and failed to ensure 5 of 5 medication carts were maintained in a sanitary condition. Findings include: R44 was interviewed on 6/4/18 at 5:34 p.m., and stated staff did not utilize alcohol wipes to sanitize the catheter drainage bag tube after they emptied it. In addition, R44 stated staff do not always wash their hands between cares and stated, "I have huge concerns about infection control here." According to a Brief Interview for Mental Status (BIMS), R44 was assessed as cognitively intact on 4/21/18.	21375	Corrected	7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 27 During an observation on 6/6/17, at 7:01 a.m. nursing assistant (NA)-A entered R58's bedroom which was shared with R44, donned a pair of gloves, wet a washcloth in the bathroom sink and washed R58's face. NA-A proceeded to wash under R58's breasts and the front perineal area. NA-A had R58 turned to the side, and NA-A washed R58's rectal area. While wearing the same gloves, NA-A applied a clean incontinent brief on R58, applied gripper socks to R58's feet, and dressed R58 with pants and a shirt. Without washing hands, or removing gloves, NA-A was observed to handle the remote control mechanism on the bed, touched the clothing in R58's closet, assisted R58 to sit up on the side of the bed, put R58's shoes on, and transfered R58 to the wheel chair. NA-A, then fingered through R58's hair in a brushing fashion. NA-A adjusted the brakes on the wheel chair and continued to open the bedside drawers looking for a hair brush, moving the trash can and replacing the trash can liner. NA-A then removed the gloves and left the room without using hand sanitizer, or washing hands. At 7:20 a.m. on 6/6/17, NA-A returned to the shared bedroom of R58 and R44 wearing gloves. NA-A had a trash bag of linens in her hands which NA-A set on the floor by the closed bedroom door. NA-A removed the gloves and discarded in the bathroom trash and donned another pair of gloves from the bathroom without hand hygiene. There were trash bags on a roll and NA-A removed a trash bag from the roll and placed it into the trash container. NA-A removed the gloves and left the room without hand washing or sanitizing. At 7:24 a.m. on 6/6/17, NA-A returned to the room with a clean incontinence brief, transfer belt and	21375		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 28 wash cloths. NA-A was unable to go into the bathroom because someone from the adjoinning room was in the bathroom. NA-A left the room to obtain gloves, then returned to the room and picked up the trash bag from the floor that had been brought in from another area and placed that bag into the trash can, before donning a pair of gloves without hand washing or sanitizing. NA-A then began cares for R44. NA-A was observed to go into R44's closet to get clothing, and to obtain supplies from R44's dresser drawers. NA-A was observed to attempt to thread R44's catheter tubing and full urinary drainage bag through R44's pants. R44 directed NA-A to empty the urine from the bag first. At that time, NA-A went into the bathroom to obtain a graduate to drain the urine into. NA-A set the graduate on the floor without a barrier, drained the urine from the tubing, used a napkin to wipe drips of urine from the tip of the tubing, took the graduate to the bathroom and poured the urine into the toilet, rinsed the graduate with water from the sink, poured the water into the toilet, set the graduate container on the back of the toilet tank, and crumbled a paper towel which she put into the graduate container. NA-A then removed the gloves and donned another pair without any hand hygiene. NA-A wet multiple washcloths in the bathroom to be used for R44. One of the wet wash cloths fell on the floor and NA-A picked it up and placed it into the bag that was in the trash can. NA-A verified that particular trash bag contained contaminated linen. When asked where the bag of soiled linens came from, NA-A stated, "I should not have brought that in here." Then NA-A removed the gloves and left the room with the trash bag of dirty linen. NA-A returned to the bedroom reapplied gloves without hand hygiene, and proceeded to thread the catheter drainage bag and tubing through R44's pants.	21375		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 29	21375		

NA-A washed R44's buttocks and rectal area prior to reaching for a tube of peri guard. NA-A opened the peri guard and applied the ointment on R44's rectal area. NA-A then applied a brief, put on R44's pajama bottoms, removed a trash bag from a roll of bags sitting on the night stand, picked up R44's tennis shoes, adjusted R44's wheel chair to be closer to the bed, made the bed and adjusted the pillows, all without having removed the gloves, or performed hand hygiene. NA-A left the residents rooms with the gloves on, went down the hall to the dirty utility room, punched in a key code and disposed of the dirty linen and trash. At that time, NA-A finally removed the gloves, but still did not use hand sanitizer or wash her hands.

When interviewed on 6/6/18, at 7:55 a.m. NA-A was unable to state how long hands should be washed, but stated, "maybe for 5 seconds."

When interviewed on 6/6/18, at 8:00 a.m. licensed practical nurse (LPN)-A stated, "Hands should be washed for 60 seconds."

The facility policy Hand Hygiene Guidelines dated 11/28/17, included: "Rubbing hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers; rinsing hands with water and drying thoroughly with a disposable towel; and turning off the faucet on the hand sink with the disposable paper towel."

When interviewed on 6/6/18, at 8:44 a.m. registered nurse (RN)-A verified the facility expectation would be to follow the facility policy for handwashing, or alcohol gel use, whenever changing gloves.

The facility policy Perineal and Catheter Care

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 30 dated 2015, included: "Emptying a urinary drainage bag. To begin, gather your supplies including a protective barrier, graduate, and an antiseptic wipe such as an alcohol pad. Be sure to provide privacy, perform hand hygiene, and apply gloves. Place the barrier on the floor underneath the drainage bag. Place the graduate on top of the barrier. Once the urine has drained, close the clamp and wipe the end of the drain tube or clamp with the antiseptic wipe to remove any residual urine. Cleanse the graduate according o your organization's policy and return to its storage location. Remove your gloves, discarded, and perform hand hygiene." When interviewed on 6/6/18, at 8:44 a.m. RN-A verified staff were expected to follow the policy for perineal cleansing and catheter care. During an observation of the third floor medication room on 6/6/18 at 8:14 a.m., LPN-B verified the two medication carts had multiple splatters of different colored substances, tan, brown, pink and black, throughout the drawers and outside of the carts. In addition, there were multiple pills on the bottoms of the medication drawers that had fallen out of the blister pack systems the facility utilizes, and cardboard and paper debris throughout the drawers. The third floor medication room floor was observed to be dirty and gritty with a heavy accumulation on the floor of sand and paper particles, as well as hair and grime. The counters and cubicles had a heavy accumulation of gray matter, dust particles, debris present. The sink had a thick scum gray and tan substance accumulated all throughout the sink and faucet handles. The Formica on the side of the cupboard by the sink was water damaged, splintered, bubbling, crumbling and was not a cleanable surface.	21375		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 31 During an observation of the second floor medication room on 6/5/18, at 10:33 a.m. LPN-C verified the two medication carts were soiled with multiple splatters of different colored substances throughout the drawers and the outsides of the carts. As on the third floor, the medication carts were noted to have pills in the bottoms of the medication drawers that had fallen out of the blister packs, and there was cardboard and paper debris throughout the drawers. The second floor medication room floor was also dirty and gritty with a heavy accumulation on the floor of sand and paper particles, as well as hair and grime. The counters and cubicles had a heavy accumulation of gray matter, dust particles, debris present. The sink had a thick scum gray and tan in color accumulated all throughout the sink and faucet handles. The cubicles had multiple layers of cellophane tape throughout the surface which was rolled and discolored from soiling. RN-J verified the tape on the cubicles was not a cleanable surface. During an observation of the Medication room on the fourth floor on 6/5/18, at 10:48 a.m. LPN-D and LPN-E verified the medication cart was soiled. The cart had splatters of different colors, pills at the bottom of the medication drawers that had fallen out of the blister packs, and there were paper particles and small pieces of cardboard throughout the drawers of the medication cart. The fourth floor medication room floor was also dirty and gritty. The counters and cubicles had a heavy accumulation of gray matter, dust particles, debris present. The sink had a thick scum gray and tan in color accumulated all throughout the sink and faucet handles. During the observation, LPN-D and LPN-E verified the nurses are responsible to keep the medication carts clean	21375		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 32	21375		

but they did not know who was responsible for the deep cleaning of the medication carts or medication rooms.

The director of housekeeping (DH) reviewed the medication room and cart findings on the morning of 6/6/18. At 11:46 a.m., DH verified the house keeping department was responsible to clean the floors, counters and sinks in the medication rooms but stated nursing staff were supposed to let them know when it needed to be done. DH stated there was no specific policy and procedure for cleaning the medication carts and the medication rooms.

When Interviewed on 6/6/18, at 11:50 a.m. housekeeper (H)-A who works full time on the fourth floor verified the housekeeping staff are dependent upon the nursing staff to let them into the locked medication rooms. H-A stated, "Often it is difficult to get the nurse to open the doors. I typically just empty the trash and make sure there are paper towels available."

When interviewed on 6/6/18, at 11:55 a.m. H-B who works full time on the third floor verified the housekeeping staff were dependent on the nursing staff to let them into the locked medication room and stated, "Usually replacing paper towels and emptying the garbage is pretty much all that is done in the med rooms because we have to get the nurses to open the door."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review infection control practices during personal cares and educate staff. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 33 services are implemented in order to reduce the risk of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis 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 document review and interview, the facility failed to ensure tuberculosis (TB) screening was conducted in accordance with facility policy and the Center for Disease Control	21426	R26, R50, R62 and R75 did not have TB screening prior to admission and 4 staff members did not have TB screening on file.	7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 34 (CDC) guidelines for 4 of 5 residents (R26, R50, R62 and R75) reviewed for TB screening upon admission, and 4 of 5 employees (E-A, E-B, E-C and E-D) reviewed for TB screening upon hire. Findings include: R26 was admitted to the facility 7/28/14, per admission record. R26's medical record lacked documentation of TB symptom screening. R50 was admitted to the facility 4/22/18, per admission record. R50's medical record lacked documentation of TB symptom screening. R50's medical record included documentation of R50 having received a first two-step tuberculin skin test (TST) on 4/22/18. Although the results were documented as negative, the results were not documented to include millimeters of induration and did not received the second two-step TST. R62 was admitted to the facility 5/4/18. R62's medical record included documentation of R62 having received a first two-step tuberculin skin test (TST) on 5/23/18. However, the results were documented neither as negative nor as the millimeters of induration and did not received the second two-step TST. R75 was admitted to the facility 5/1/18. R75's medical record included documentation of R75 having received a first two-step tuberculin skin test (TST) on 5/12/18. Nevertheless, the results were documented neither as negative nor as the millimeters of induration and did not received the second two-step TST. E-A was hired on 3/6/18, and did not received a TB symptom screening and the two-step TST.	21426	R26, R50, R62 and R75 now have completed TB screening. An audit was completed on all residents. Tracking for residents will be done through Point Click Care. An audit was completed for staff members on 6/22. All staff will have completed TB screening by 7/18. All new employees will begin the TB screen process during the orientation tour. They will be given the required reading date and will not be able to work until they have it read. Then the infection control nurse will provide the 2nd step dates to the employee. Complete compliance will be completed by 7/18. DON/designee to monitor.	

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 35 E-B was hired on 3/27/18, and did not received a TB symptom screening and the two-step TST E-C was hired on 4/3/18, and did not received a TB symptom screening and the two-step TST E-D was hired on 3/6/18, and received Quantiferon-TB Gold blood test with negative result however, did not received a TB symptom screening. On 6/5/18 at 1:16 p.m., the director of nursing (DON) and corporate nurse consultant (CNC) confirmed that TST documentation was supposed to include the baseline TB symptoms screening, 2-step testing, millimeters of induration, and interpretation of reading. CNC indicated, she identified the documentation was lacking TST steps and TB symptoms screening. CNC added, "This does not meet the facility expectations, staff will be retrained/reeducated on this concerns". On 6/6/18 at 9:21 a.m., the DON verified that TST documentation was supposed to include the baseline TB symptoms screening, 2-step testing, millimeters of induration, and interpretation of reading. DON stated, "This is not our expectation and we will put system in place and retrain/reeducate all our staff members on the TST procedures. Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening Health Care Workers (HCWs) directed "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative Interferon-Gamma Release Assays [IGRA] (blood test) or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed	21426		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 36 after the HCW starts working with patients... Serial TB screening Serial TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a one-step TST or single IGRA... General principles ·All reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations should be maintained in the employee's record. ·TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative) ..." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies regarding TB screening, could educate staff and could ensure audits were conducted to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy;	21535		7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 37 B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to monitor for potential adverse consequences for 1 of 5 residents reviewed (R17) for unnecessary medications. Findings include: Review of the facility's Psychotropic Medication Management policy, effective 11/28/17, defined adverse consequence as "an unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status." The adverse consequence procedure clarified, "Residents on psychoactive medications are monitored daily for adverse consequences," and directed staff to contact the medical doctor or nurse practitioner	21535	Corrected	

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 38	21535		

regarding any medication-related adverse consequences. Psychoactive Medications were defined as any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders.

Review of R17's Admission Record revealed R17 had diagnoses including unspecified dementia without behavioral disturbance, major depressive disorder, and intracranial injury.

Review of current medication orders and the medication administration record (MAR), indicated R17 utilized the following psychoactive medications: Aripiprazole (antipsychotic medication also known as Abilify) 20 milligrams (mg) daily to treat depression and traumatic brain injury with psychotic features; Bupropion (antidepressant medication) 150 mg daily to treat major depressive disorder, Trazadone (antidepressant medication) 200 mg at bedtime for insomnia, and Venlafaxine (antidepressant medication also known as Effexor) 225 mg daily for major depressive disorder.

According to the most recent annual Minimum Data Set (MDS) assessment dated 12/22/17, R17 had received antipsychotic and antidepressant medications daily during the 7 day look back period. A Care Area Assessment (CAA) for the area of psychotropic drug use indicated: "[R17] receives psychotropic [medications] for management and treatment of psychosis, depression, and insomnia. Staff observe for potential side effects, effectiveness of [medications], and any mood/behavioral indicators. Monitored per [medical doctor] and facility policy."

R17's current electronic record care plan

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 39	21535		

reviewed 6/7/18, indicated R17 used antipsychotic medications related to the diagnosis of depression with psychotic features, and auditory hallucinations. The care plan listed the goal of no negative outcomes resulting from use of antipsychotic medications, and to be free of drug related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment. The care plan noted use of antidepressant medications related to diagnosis of depression, and listed a goal for R17 to be free from discomfort or adverse reactions related to antidepressant therapy. The care plan also indicated R17 had a potential risk for alteration in psychosocial well-being related to depression, and long time use of psychotropic medications. An intervention indicated staff were to administer medications as ordered, and monitor for/document side effects.

During interview on 6/7/18, at 10:18 a.m. licensed practical nurse (LPN)-E said any required side effect monitoring was completed by the nurses on the treatment administration record (TAR).

Review of the MARs and TARs failed to provide evidence staff monitored R17 daily for potential side effects or adverse consequences from psychotropic medication use.

During interview on 6/7/18, at 1:17 p.m. the director of nursing (DON) confirmed nurses should be monitoring and documenting side effects daily on the TAR. The DON reviewed the TAR and was unable to find evidence of daily monitoring. The DON said the facility had switched from paper MAR and TAR forms, to electronic forms in February 2018. The DON explained that side effect monitoring was

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 40	21535		

automatically printed on the paper MAR/TAR forms, but when the facility switched to use of the electronic MAR/TAR, the daily side effect monitoring had to be entered as an order before the monitoring would show up as a daily task. The DON confirmed nursing staff had not been monitoring R17 daily for side effects on the TAR, and believed this had happened since the February switch to the electronic MAR/TAR. During the course of the interview, the DON entered an order for nursing to monitor R17 daily for side effects.

The facility's consultant pharmacist had documented a recommendation for R17 on 6/5/18: "Use of two or more antidepressants simultaneously may increase risk of side effects; in such cases, there should be documentation of expected benefits that outweigh the associated risks and monitoring for any increase in side effects." The pharmacist recommended re-evaluation of the need/benefit for the three antidepressants and antipsychotic medications, and if the therapy was to continue, recommended the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences such as dizziness, nausea, diarrhea, anxiety, nervousness, insomnia, somnolence, weight gain, anorexia, or increased appetite or falls.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the policy and procedures for use of psychoactive medications with the licensed staff to meet the requirements of the state and federal regulations including monitoring for adverse consequences with the use of psychoactive medications,.

TIME PERIOD FOR CORRECTION: Twenty-one

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 41 (21) days.	21535		
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. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary and orderly environment. This affect 2 residents (R38, R40) with unpainted walls, 8 residents with shared bathrooms (R6, R38, R40, R42, R43, R44, R57, R58), 5 residents (R38, R40, R43, R57, R3) with unkept privacy curtain, all residents and visitors on third and fourth floor who used the public water fountains and all residents who use the third floor storage room. Furthermore, the unclean elevator floor surfaces had the potential to affect all visitors and residents who used the elevators. Findings include: When interviewed on 6/4/18, at 2:00 p.m. R38 and R40 verified in their room that the east wall had a 5 foot by 5 foot area that had been scraped and patched and was missing a painted surface. According to R38 the wall area had been like that "for several weeks." The overhead privacy curtains were missing hooks, and one of the overhead privacy curtains had a large tear in the	21695	Corrected.	7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 42 mesh section of the curtain. The bathroom had a black brown gray area around the toilet base that appeared to be an uncleanable surface on the grout and there was a stale odor that permeated the bathroom. During an observation on 6/4/18, at 4:00 p.m. R44 and R58 pointed to the ceiling area running the extent of the bedroom that appeared dark brown and black in color against the white ceiling that did not appear clean. R44 expressed concern that the bathroom was not clean and sometimes there was an odor "like old urine" in the bathroom. The toilet base grout had a black brown grime build up and there was a strong odor of urine detected. R44 expressed the bathroom is shared by 4 residents (R6, R42) and according to R44 the bathroom is "not cleaned very well every day. " During an interview on 6/4/18, at 6:00 p.m. R43 expressed concern about seeing bugs in the bedroom and bathroom and that the bathroom was not clean. Observation of the bathroom revealed the grout around the base of the toilet tank was black and brown in areas and the floor was separating from the grout area. The bedroom privacy curtains were missing hooks and the privacy curtain was stained with large gray splatters. R57 was R43's roommate and verified the findings. During observation throughout various dates and times upon entering the facility 6/4/18, the public water fountain on third and fourth floor had a reddish brown substance appearing around the drain as well as a heavy accumulation of white lime like substance on the spigot of the water fountain.	21695		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 43 During observation upon entrance to the facility on 6/4/18, at 11:30 a.m. and throughout various times in the facility, the small and large elevators had multiple tears and gouges in the flooring that prevented the surface from being cleanable as bare wood was exposed in multiple areas. When interviewed on 6/7/18, at 2:00 p.m. the administrator was aware of the issue with the flooring, but the company was still formulating capital expenditures that would need to be approved by the corporation. During environmental rounds with the environmental director (ED) on 6/7/18, at 8:56 a.m. verified the above findings that the facility needed a system to finish painting rooms, to go around and check the privacy curtains, and the grout replacement around toilet bases needed to be evaluated. Furthermore, the maintenance director verified the public water fountain drains needed to be replaced and the faucet parts needed to be de-limed. The ED verified there was not a facility policy on these issues but when staff noted the issues they should be documented on the request form located at each nursing desk. The ED verified the facility did not have a routine system to check for room painting, privacy curtains, toilet grout, water fountains, and relied on the housekeepers and nursing staff to report issues. 06/04/18, 01:26 PM the privacy curtains mesh in the middle is torn with a large hole, curtain hooks missing and loose and difficult to pull on the curtain on the track and hooks loose as well and resident stated that is been more than five months and told the housekeeping manager and they did not do anything about it. On 6/6/18, at 10:13 a.m., the privacy curtains still	21695		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 44 remain torn and have loose tracks and difficult to pull and observed licensed practical nurse (LPN)-F having difficult time pulling the privacy curtain to give resident privacy. LPN-F and LPN-D verified the finding and LPN-F indicated, "I will tell [housekeeping director] from house keeping to come take a look at it." On 6/6/18, at 10:33 a.m., housekeeping (HK-A) verified that privacy curtain in the middle had a large torn and the one by the foot of the bed had multiple areas that the hooks are off and some hooks are holding the curtain are missing as well. HK-A stated, "I am new here just started working here I transferred from another facility". On 6/6/18, at 10:39 a.m., Housekeeping Director (HD) verified the privacy curtain in the middle had large tears and the one by the foot of the bed had multiple areas that the curtain hooks were off the curtain mesh and some curtain hooks that were holding the curtain were missing as well. HD stated, his expectation is that curtain mesh should be replace when torn and that the curtain hooks should be holding the curtain in place. He stated he was going to do the curtain audits on this floor today and will make sure those are taken care of. He continued by explaining, normally the torn curtains are removed and replace with new ones. I am going to ask the maintenance director (MD-G) to order new ones for the resident. The policy and procedure titled CLEANING CUBICLE CURTAINS, dated 6/2016, read, "Examine curtains while doing QCI or at discharge... If curtain is torn - replace. If curtains are off hooks. repair... Have additional hooks available for repair. Have spare curtains on hand to immediately replace dirty or torn curtains..."	21695		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 45 During a random observation on 6/7/18, at 10:15 a.m., surveyor observed the storage room on 3rd floor by the nursing station while a resident was getting ice. This surveyor noted that the resident weight scale was in the room and the carpet had multiple black spots, large areas of red stained spots, paper crumbs and ice buckets were in the room. During an interview with (LPN)-J on 6/7/18, at 1:31 p.m., stated that staff normally weigh resident in the storage room and the weight scale is kept in there. During an interview with (LPN)-A on 6/7/18, at 1:36 p.m., stated that staff normally weigh residents in the storage room and the weight scale and ice bucket are normally kept in this room. LPN-A added that the storage room is always filthy and has been for months; stating the Administrator was informed nothing has been done yet. During an interview with the administrator on 6/7/18, at 12:41 p.m., observation of the 3rd floor storage room was verified. The admin stated she spoke with MD-G regarding carpet condition in the 3rd floor storage and there is a plan in place to replace the carpet. Also, the maintenance staff is on work restriction and have to wait until regional maintenance director comes back to work for them to complete task together. No date is set yet. No work order was available for review. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative	21695		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 46 maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the	21830		7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 47	21830		

family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 48 members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement a plan of care based on resident preferences for 5 of 5 residents (R52, R44, R58, R50, R43) reviewed for choices. Findings include: When interviewed on 6/4/18, at 1:11 p.m. R52 who was assessed as cognitively intact 4/20/18, indicated she was in bed watching television and stated, "I think I am coming down with a cold and just want to stay in bed and watch TV."	21830	R44 stated the R58 was not always treated with dignity by the aides. The aide would leave R44 and R58 uncovered with the privacy curtain open. The aide has since terminated from Galtier. Reeducation for all staff on resident dignity completed on 6/28, 6/29 and 7/2. The Activities department will visit with each resident and discuss 5 things the residents would like staff to know about them. Resident likes sign will hang in the resident's room for staff. Staff will be educated on resident preferences and the	

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 49 Furthermore, R52 stated, see that sign says we cannot watch TV after 10:30 pm, and when I don't feel well and wake up at night I sometimes like to turn on the TV because I know my roommate does not mind." R52 indicated no one has ever talked to her about the "rule" and expressed "The rule is too strict especially if my roommate doesn't mind the television being on low." Surveyor observed a laminated sign on R52's bedroom wall that reads," Attention Residents, families and staff. All TV's are to be turned off at 10:30 p.m. This time has been determined by the Resident Council." The sign was dated 1/19/2010. When interviewed on 6/4/18, at 6:04 p.m. R44 and R58 were together is a shared bedroom. The residents were talking about choices in the facility and R44 pointed to a duplicate laminated sign observed in R52's room. R44 stated 2nd and 4th floor did not have these signs posted so he did not understand why 3rd floor had to. R44 stated, "That's not right, If I am awake during the night and want to quietly watch TV, then that should be allowed." Roommate R58 was nodding head in agreement and stated "Yes." R44 was assessed as cognitively intact 4/21/18, and R58 was assessed as cognitively intact 5/2/18. When interviewed on 6/4/18, at 6:55 p.m. R50 who was assessed as cognitively intact 4/27/18, expressed the facility's TV rule was not accommodating for R50's needs or choices. R50 explained that it is not unusual to have difficulty sleeping at night and usually having the television on for awhile during the night helps. R50 stated this has been expressed to various staff that this	21830	sheets hanging in the room. DON to audit personal cares daily x7, weekly x 4 and quarterly thereafter. Staff members will be reeducated on the spot. Audit will be discussed at monthly QAPI. DON/designee to monitor	

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 50 is not a good rule for R50. R43 was assessed as having mild cognitive impairment on 4/18/18. R43 expressed that the rule was "too strict" because there are times when she is not able to sleep during the night and wants the ability to turn on the television. R43 said she has asked about the rule but the staff don not seem to have an answer if the rule is accurate or enforceable. R43 requested staff ask the director of nursing for "head sets" but was told they do not work because of the way the television is connected. R43 would like the facility to obtain proper head sets so if she wakes during the night she will have the ability to watch television if she chooses. The laminated sign dated 1/19/2010, was also observed to be posted at the nurses' station. When interviewed on 6/6/18, at 8:26 a.m. registered nurse (RN)-A and the social service designee (SSD) expressed being fairly new to the third floor and not aware of the resident concerns about the restriction regarding television being used after 10:30 pm. Being the sign posted was from 2010, RN-A and SSD agreed the facility should re-visit the rule and accommodate each individual residents choices as best they could. The facility does not have a policy regarding watching television after 10:30 p.m. at night. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure facility has a system to know residents' likes and dislikes, including choices regarding activities, daily routines and participation in the community.	21830		

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 51 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 2 of 5 residents (R44, R58) reviewed who required staff assistance with personal care. The findings include: During interview with R44 on 6/4/418 at 5:34 p.m., R44 stated staff did not always treat her roommate (R58) or herself with dignity. During observation in of care on 6/6/18 at 7:01 a.m., a nursing assistant (NA)-A was observed to approach R58 in her room and began to provide assistance with morning care. NA-A did not pull the privacy curtain and R44 was present in the room. NA-A washed R58's face, then continued to remove R58's clothes and washed under her	21855	A sign was posted in a public area that Resident Council voted for TVs to be off by 10:30pm which was votedon 10 years ago. Surveyors found the facility failed to comprehensively implement a plan of care based on resident preferences. This sign has now been taken down and it was discussed at the April resident council meeting. The Activities department will visit with each resident and discuss 5 things the residents would like staff to know about them. It will hang in the resident's room for staff to know them better. Staff will be educated on resident preferences and the sheets hanging in the resident's room. Facility will be in compliance by 7/18. Resident Council will discuss and concerns will be brought to the	7/18/18

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21855	Continued From page 52 breasts and the front of R58's perineum. NA-A then gestured with her hand for R58 to turn over and NA-A continued to cleanse R58's buttock. On 6/6/18 at 7:24 a.m. NA-A approached R44 and applied her stockings. NA-A then attempted to put R44's urinary catheter bag and tubing through a pair of leggings R44 was going to wear. R44 stated, "you have to empty the urine before it will fit in there." NA-A stepped away from the bedside, leaving R44 uncovered, with the privacy curtain open. R58 was present in the room at that time. NA-A left the residents' room and when she opened the door, there was a resident walking by in the hallway who looked into the room where R44 lay uncovered on her bed wearing only an incontinent brief. At that time, R44 stated, "See what I mean, she [NA-A] has an attitude and is not respectful of me." R58 was interviewed on 6/6/18, at 8:20 a.m. and stated, "She [NA-A] does not give me privacy." R58's cognitive assessment dated 5/2/18, indicated R58 was cognitively intact. The plan of care dated 6/21/17, included interventions for staff to assist the resident with all grooming and dressing due to decrease in muscle strength and impairment of range of motion due to a history of stroke. Interventions also included: "Explain all procedures/tasks before starting and promote dignity by ensuring privacy." R44's plan of care dated 4/17/18, indicated R44 was able to participate with aspects of self care with assistance: button shirts, tie shoes, use zipper, put on shirt, pull up pants, put on socks. R44's cognitive assessment dated 4/21/18, indicated R44 was cognitively intact.	21855	Administrator to be discussed at monthly QAPI. Administrator/designee to monitor.	

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21855	Continued From page 53 During interview with registered nurse (RN)-A and social service designee (SSD) on 6/6/18 at 9:56 a.m., they verified the facility expectation was to follow the Resident Bill of Rights (which includes provision of privacy), and to treat all residents with respect and dignity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could establish training initiatives for employees to ensure Resident Rights, including privacy and dignity are a clearly defined facility practice. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21855		