

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 2, 2020

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

RE: CCN: 245340 Cycle Start Date: November 13, 2020

Dear Administrator:

On November 13, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: sarah.grebenc@state.mn.us Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by February 13, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 13, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

Daventes Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 2, 2020

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

Re: State Nursing Home Licensing Orders Event ID: TJ1U11

Dear Administrator:

The above facility was surveyed on November 12, 2020 through November 13, 2020 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Sarah Grebenc, Unit Supervisor Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: sarah.grebenc@state.mn.us Office: (651) 201-3792

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,

Dovertes Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program

Galtier A Villa Center December 2, 2020 Page 3 Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMP	SURVEY LETED
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	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	was conducted to d State Licensure. Yo in compliance with Please indicate in y correction that you and identify the date	S: 220, an abbreviated survey etermine compliance with ur facility was found to be not the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 12/10/20

STATE FORM

If continuation sheet 1 of 8

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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			AUL, MN 5510				
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2 000	Continued From pa	ge 1	2 000				
	substantiated: H534 issued. The facility is enroll	laint was found to be 40062C with a licensing order ed in ePOC and therefore a uired at the bottom of the first					
21925	MN St. Statute 144. Residents of HC Fa	651 Subd. 29 Patients & c.Bill of Rights	21925			12/11/20	
	shall not be arbitrar Residents must be proposed discharge justification no later discharge from the transfer to another in notice shall include the proposed action telephone number of ombudsman pursua Act, section 307(a)(of this right, may ch notice period ends. shortened in situation control, such as a do review, the accommon residents, a change treatment program, resident's welfare, of prohibited by the pu- paying for the reside the medical record.	than 30 days before facility and seven days before room within the facility. This the resident's right to contest and the address and of the area nursing home and to the Older Americans (12). The resident, informed toose to relocate before the The notice period may be ons outside the facility's letermination by utilization nodation of newly-admitted in the resident's medical or the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a accommodate new residents	5				
		ent is not met as evidenced					

TJ1U11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00480			(X3) DATE SURVEY COMPLETED C 11/13/2020		
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	facility failed to ens a proper discharge include written notif discharge, a discha to include the numb	and document review the ure the facility failed to ensure process was followed to fication of the reason for arge location and appeal rights per for the ombudsman for 1 of viewed for transfer and		Corrected			
		eet indicated an admission d a discharge date of 11/9/20.					
	dated 9/17/20, indic not rejected care no status had not char assessments. R1 re transfers and super and locomotion on schizophrenia. R1 alarm which was us	ange Minimum Data Set (MDS) cated intact cognition. R1 had or wandered. R1's behavior nged compared to prior equired limited assistance with rvision with walking in room unit. R1 had a diagnosis of had a wander/elopement sed daily. R1 did not have an an to return to the community.					
	indicated around 6: room. Staff began The supervisor, dire	dated 10/31/20, at 9:34 p.m. 30 p.m. R1 was not in their a facility wide check for R1. ector of nursing (DON), R1's ere informed and an outside d.					
	indicated R1 had no updates from police The medical record	dated 11/1/20, at 5:49 a.m. ot been located yet and no e or family had been received. I lacked any further o R1's whereabouts.					
	dated 11/1/20, and investigation was st	orts to the state agency (SA) 11/3/20, indicated an tarted when R1 was observed the facility. The facility					

ES (X1) PROVIE I IDENTIF	ICATION NUMBER:	A. BUILDING: _		Сом (E SURVEY PLETED	
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owed R1 left the b om trays and there areas. R1 was a cut off their wande itive ability to do s the facility. ntry point report to cated R1 was adm The facility decline d a placement diffied d R1 a dischar d discharge summ was admitted to fa 38 p.m. accompa- nician (EMT) personal otel after eloping f itted to hospital as ome will not take om the facility for of hospital, psychiat of capacity for dis- iew by phone on al social worker (S adult because the c. SW-A stated the c even though R1 ce initial admissio was not in R1's b a hospital. SW-A a not notified of right a bed hold. Late e decided to acce	efore not present in ssumed to have erguard. Further, R so, and made a o the SA, dated hitted to the hospital ed to take R1 back ficulty. The facility ge notice. ary dated 11/9/20, the hospital at on unied by emergency sonnel. R1 was rom Galtier Villa. s vulnerable adult R1 back, since R1 over 24 hours. ry was consulted for scharge. 11/12/20 at 9:18 W)-A stated on d to the hospital as e facility would not is condition had not is condition had not is condition had not is not 11/4/20, the pt R1 back at	1 1 /				
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R1 was botel after eloping from Galtier Villa. itted to hospital as vulnerable adult ome will not take R1 back, since R1 pom the facility for over 24 hours. hospital, psychiatry was consulted for of capacity for discharge. view by phone on 11/12/20 at 9:18 al social worker (SW)-A stated on had to be admitted to the hospital as adult because the facility would not k. SW-A stated the facility would not k. SW-A stated the facility would not k even though R1's condition had not k even though R1's best interest to a hospital. SW-A also had concerns not notified of rights related to to a bed hold. Later, on 11/4/20, the e decided to accept R1 back at ation, a sister facility with a locked ility had requested hospital to start	IES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER: A. BUILDING: 00480 B. WING JPPLIER STREET ADDRESS, CITY, S' ITER 445 GALTIER AVENUE SAINT PAUL, MN 5510 IMARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RRY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG owded R1 left the building while staff om trays and therefore not present in a areas. R1 was assumed to have cut off their wanderguard. Further, R1 nitive ability to do so, and made a e the facility. 21925 entry point report to the SA, dated cated R1 was admitted to the hospital The facility declined to take R1 back, d a placement difficulty. The facility rided R1 a discharge notice. I I discharge summary dated 11/9/20, was admitted to the hospital at on :38 p.m. accompanied by emergency nnician (EMT) personnel. 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Minnesota Department of Health

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	During interview by phone on 11/12/20, at 11:20				
		r (FM)-A stated is typical for			
		health problems and memory			
		had been updated that R1			
		ne when nobody was around.			
		notel and brought to a hospital.			
		ome concerns over how R1			
		ne facility and about lack of acility. FM-A stated R1 had			
		ged and moved to a different			
	facility.	ged and moved to a different			
	racinty.				
	During interview by	phone on 11/12/10, license			
		N)-A stated was familiar with			
		otified the day R1 eloped.			
		ormally needed constant			
	redirection, R1 was	"always trying to leave".			
	LPN-A stated this h	ad been the case for most of			
	R1's stay. LPN-A st	ated was unsure of any			
		prevent her coming back			
		t. LPN-A stated would not have			
		issue a bed hold or discharge			
	notice.				
	During interview on	11/12/20 at 12:17 p.m. DON			
		tated when a resident was			
		ospital, that should be			
		progress notes. Then a bed			
		e completed. DON and			
		they could not take R1 back			
		ed to be in a locked unit. DON			
		ig history of being high risk for			
		d in the past and would			
		ntly, for most of R1's stay staff			
	were to check the v	vanderguard on night shift for			
	function and monito	or its placement every shift.			
	DON stated since F	R1 had successfully eloped			
		e hospital recommended a			
	locked unit. DON st	tated social services would be			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
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			AUL, MN 5510			
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21925	Continued From pa	ge 5	21925			
	rights to be informe Facility documentat and determined not the facility. The ass not provided. During interview on services director (S R1. SSD stated typ the hospital, social ask if they want the not done this becau and when SSD retu business day faciliti admissions office d to return. SSD state	e notices related to resident ad of discharge or transfer. tion that R1 was reassessed to be able to come back to sessment was requested but 11/12/20 at 1:22 p.m. social SD) stated was familiar with ically when a resident goes to services would check in and ir bed hold. SSD stated had use R1 eloped on a weekend uned to work on the next ty management and the ecided R1 was not appropriate ed was unsure who would do f rights related to discharge or				
	pm, registered nurs with R1 and had be RN-A had initiated a resident including o wanderguard's to e placement. RN-A st care for residents th RN-A stated would issuing a bed hold o	nsure proper function and tated the facility was able to nat were at risk for elopement. not have been responsible for or discharge notice.				
	a.m. admissions co been involved in the AC-A stated the hos could be readmitted concern that R1 has unsure R1's safety readmitted. AC-A st	phone on 11/13/20, at 9:13 ordinator (AC)-A stated had e readmissions consult for R1. spital had called to see if R1 d. AC-A stated there was a d eloped and they were could be maintained if tated was not responsible to e medical record, it was				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			C
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AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ALTIER	A VILLA CENTER		IER AVENUE UL, MN 5510	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21925	Continued From pa	age 6	21925			
	discussed as a tea	m.				
	a.m. R1 stated was moved from the ho home. R1 stated h	/ phone on 11/13/20, at 9:35 s doing "ok" and had been ospital to a different nursing nad not been provided any e facility related to her sfer.				
	p.m., administrator may have been lac the COVID-19 out	/ phone on 11/13/20, at 3:00 stated their documentation king because their focus was preak. The DON stated if there ay for R1 to return they would back.				
	dated 11/28/20, ind who voluntarily or in from the facility will not be involuntarily circumstances meet regulations and law representative will adequate preparati to make the transfer possible. The notice the transfer and inf appeal rights. If the emergency, the no practicable. The fa discharge notices the	sfer and Discharge Guideline dicated the rights of residents nvoluntarily are discharged l be upheld and a resident will discharged unless the et specific criteria defined by vs. The resident and receive timely notification, ion, orientation and information er as orderly and as safe as the contains information about formation about the resident's e transfer is due to an tice will be issued as soon as cility forwards a copy of all to the Office of the State imbudsman and required state ted.				
	administrator, direct designee could rev procedures that wr	THOD OF CORRECTION: The ctor of nursing (DON), or view and/or develop policy and itten notification was provided their representative before a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
ND F LAIN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00480	B. WING		C 11/13/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ALTIER	A VILLA CENTER		TIER AVENUE AUL, MN 5510	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21925	Continued From pa	age 7	21925			
	policies and audit p these audits will be	y could educate staff on these periodically. The results of reviewed by the quality ittee to ensure compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				Сом	E SURVEY IPLETED
		245340	B. WING				C 13/2020
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		13/2020
				4	45 GALTIER AVENUE		
GALTIER	A VILLA CENTER			S	SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00			
	was completed at y complaint investiga not to be in complia Requirements for L	13/20, an abbreviated survey rour facility to conduct a tion. Your facility was found ance with 42 CFR Part 483, ong Term Care Facilities.					
		plaint was found to be 40062C, with a deficiency cited					
		f correction (POC) will serve of compliance upon the ptance.					
	signature is not req page of the CMS-28	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.					
E 622	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with	F 6				12/11/20
F 623 SS=D		ts Before Transfer/Discharge 3)-(6)(8)	FO	023			12/11/20
	resident, the facility (i) Notify the resider representative(s) of the reasons for the language and mann facility must send a representative of th	nsfers or discharges a r must- nt and the resident's f the transfer or discharge and move in writing and in a ner they understand. The copy of the notice to a le Office of the State					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						12/10/2020

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.

PRINTED: 12/14/2020

		AND HUMAN SERVICES				FORM	12/14/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245340	B. WING				C I 3/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIEF	R A VILLA CENTER				445 GALTIER AVENUE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Long-Term Care Or (ii) Record the rease discharge in the rease accordance with para and (iii) Include in the net paragraph (c)(5) of §483.15(c)(4) Timin (i) Except as specified (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be rease before transfer or d (A) The safety of into be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's health of in be endangered in the foll (i) The reason for t (ii) The effective data	mbudsman. ons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in this section. of the notice. ied in paragraphs (c)(4)(ii) and n, the notice of transfer or under this section must be rat least 30 days before the red or discharged. made as soon as practicable ischarge when- dividuals in the facility would der paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of nealth improves sufficiently to diate transfer or discharge, o)(1)(i)(B) of this section; ransfer or discharge is dent's urgent medical needs, o)(1)(i)(A) of this section; or not resided in the facility for 30 ents of the notice. The written paragraph (c)(3) of this section llowing: ransfer or discharge; te of transfer or discharge; which the resident is	F	523	3		

If continuation sheet Page 2 of 9

STATE BUNCT OF DEFICIENCIES AND PLAN OF CORRECTION (X) PROVIDERSUPPLER 245340 (X) PROVIDER CORSUPPLER 245340 (X) PROVIDER CORSUPPLER 245340 (X) PROVIDER CORSUPPLER 245340 (X) PROVIDER CORSUPPLER 245 CALTER A VILLA CENTER (X) PROVIDER CORSUPPLER 245 CALTER A VILLA CENTER (X) PROVIDER CORSUPPLER 260 PERCENCY WILST E PRECEDED BY FULL RESULTORY OR LSC IDENTIFYING INFORMATION) (X) PROVIDER CORSUPPLER 260 PERCENCY WILST E PRECEDED BY FULL 260 PERCENCE OF OT THE APPROPRIATE DEFICIENCY (X) PRECENCY WILST E PRECEDED BY FULL 260 PERCENCE OF OT THE APPROPRIATE 260 PERCENCENCE OT THE APPROPRIATE 260 PERCENCE OF OT THE APPROPRIATE 260 P			AND HUMAN SERVICES				FORM	12/14/2020 APPROVED 0938-0391	
11/13/2020 NAME OF PROVIDER OR SUPPLIER GALTIER A VILLA CENTER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES CALTIER A VILLA CENTER SUMMARY STATEMENT OF DEFICIENCIES CALTIER A VILLA CENTER SUMMARY STATEMENT OF DEFICIENCIES CALTIER A VILLA CENTER SUMMARY STATEMENT OF DEFICIENCIES Colspan="2">Colspan="2" F 623 Continued From page 2 (v) A statement of the resident's appeal rights, including the ame, address (mailing and email), and telephone number of the othic of the State Long-Term Care Ombudsman: (v) The name, address (mailing and email) and telephone number of the agency responsible for the State Long-Term Care Ombudsman: (vi) To nursing facility residents with intellectual and developmental disabilities estabilished under Part C C of the Developmental disabilities Act: Condition dividuals with developmental disabilities assistance and Bill of Rights Act of 2000 (Pub L. 106-402, codited at 42 U S C. 15001 tes seq.); and dividuals with a mental disorder restabilished under the Protection and Advocacy of for Mentaly III Individuals Act. <td colspan<="" td=""><td>STATEMENT</td><td>OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td>l` í</td><td></td><td>E CONSTRUCTION</td><td colspan="2">COMPLETED</td></td>	<td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>l` í</td> <td></td> <td>E CONSTRUCTION</td> <td colspan="2">COMPLETED</td>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l` í		E CONSTRUCTION	COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GALITER A VILLA CENTER 445 GALITER AVENUE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MOST BE RECEDED BY FULL RECOLUCTORY OR LSC DENTIFYING INFORMATION) PREFIX PREFIX (CACH DEFICIENCY MOST BE RECEDED BY FULL RECOLUCTORY OR LSC DENTIFYING INFORMATION) PREFIX PREFIX (V) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (V) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C cofficed at 42 D20. (Fub. L. 106-402, codified at 42 D20. (Fub. L. 106-402, codified at 42 D20. (Fub. L. 106-402, codified at 42 D20. (S). (500) 1 es eq.); and (vi) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and Advocacy for Mentally III Individuals Act. \$483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practoable once the updated information becomes available. \$483.15(c)(8) Notice in advance of facility closure in the case of facility closure, the individual who is the administrator of the facility must provide			245340	B. WING					
SAINT PAUL, MN 55103 CMUID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SAINT PAUL, MN 55103 CMUID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG DEFICIENCIES PROVIDERS INJUNCTOR USC DENTIFYING INFORMATION) F 623 Continued From page 2 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Blate Long-Term Care Ombudsman; (v) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities Assistance and Bill of Rights Act of 2000 (Pub L. 106-402, codified at 42 U.S C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities. The mailing and email address and telephone number of the agency responsible for the protection and Advocacy for Mentally III Individuals Act. Ş433.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable one the updated information becomes available. Ş433.15(c)(8) Notice in advance of facility closure, In the case of facility closure, the individual who is the administrator of the facility must provide	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
Prefix TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDULATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) conhight content of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; F 623 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (v) For nursing facility residents with intellectual and developmental disabilities or related disabilities established under Part C of the Developmental Disabilities status and advocacy of individuals with developmental disabilities status and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the gency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy for Mentally III Individuals Act. §483.15(c)(8) Notice in advance of facility closure in the cace of facility closure, the individual who is the administrator of the facility must pudate information becomes available. §443.15(c)(8) Notice in advance of facility closure in the cace of facility to sure of the facility must pudate information bec	GALTIER	A VILLA CENTER							
 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (iv) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (iv) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder restablished under the protection and Advocacy for Mentally III Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION	
written notification prior to the impending closure	F 623	(iv) A statement of the including the name, and telephone numereceives such requered to obtain an appeal completing the form hearing request; (v) The name, address and developmental disabilities, the mail telephone number of the protection and a developmental disabilities, the mail telephone number of the protection and a developmental disabilities and Bill of Rights Address and Bill of Rights Address and the address address address and the address and the address address address and the address and the address address address and the address a	the resident's appeal rights, , address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State mbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with ibilities established under Part ental Disabilities Assistance ct of 2000 (Pub. L. 106-402, C. 15001 et seq.); and ility residents with a mental disabilities, the mailing and telephone number of the e for the protection and uals with a mental disorder he Protection and Advocacy iduals Act. ages to the notice. the notice changes prior to er or discharge, the facility cipients of the notice as soon e the updated information	F 6	23				

If continuation sheet Page 3 of 9

		AND HUMAN SERVICES				FORM	12/14/2020 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE SURVEY COMPLETED	
		245340	B. WING			(11/1	C 3/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIE	R A VILLA CENTER				45 GALTIER AVENUE AINT PAUL, MN 55103		
(X4) ID PREFIX TAG					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 623	to the State Survey State Long-Term C. the facility, and the well as the plan for relocation of the res 483.70(I). This REQUIREMEN by: Based on interview facility failed to ens a proper discharge include written notif discharge, a dischar to include the numb 4 residents (R1) res discharge. R1's facility face sh date of 7/22/20, and R1's significant char dated 9/17/20, indic not rejected care no status had not char assessments. R1 re transfers and super and locomotion on schizophrenia. R1 alarm which was us active discharge pla R1's progress note indicated around 6: room. Staff began The supervisor, dire family and police w search was initiated	Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at § NT is not met as evidenced and document review the ure the facility failed to ensure process was followed to ication of the reason for arge location and appeal rights ber for the ombudsman for 1 of viewed for transfer and eet indicated an admission d a discharge date of 11/9/20. Inge Minimum Data Set (MDS) cated intact cognition. R1 had or wandered. R1's behavior nged compared to prior equired limited assistance with vision with walking in room unit. R1 had a diagnosis of had a wander/elopement sed daily. R1 did not have an an to return to the community. dated 10/31/20, at 9:34 p.m. 30 p.m. R1 was not in their a facility wide check for R1. ector of nursing (DON), R1's ere informed and an outside	F	523	R1 no longer resides at the Galtier Center. Residents that reside at Galtier a vil center have the potential to be affect this practice. Policies have been rev and are current. The process for discharging a resident will be follows include; written notification explainin reason for discharge, a discharge location, and information on appeal The Social Services department hav been educated on issuing involuntat discharge notices. The education w given on December 10th, 2020 by Stephanie Quam, Administrator. Administrator/ Designee will audit involuntary discharge notices weekt weeks then monthly for 3 months. Fo of audits will be reviewed at QAPI committee monthly for continued opportunities for quality improvement	la sted by viewed ed to ng the rights. ve ry vas y for 3 Results	

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		AND HUMAN SERVICES					FORM	12/14/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	0	(X3) DATI COM	E SURVEY PLETED
		245340	B. WING					C 13/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
GALTIER	R A VILLA CENTER				45 GALTIER AVENUE SAINT PAUL, MN 55103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 623	indicated R1 had no updates from police The medical record documentation as the Facility initiated rep dated 11/1/20, and investigation was st to be missing from cameras showed R delivered room tray the common areas. removed or cut off the had the cognitive all plan to leave the fact A common entry por 11/3/20, indicated F on 11/1/20. The fact which caused a pla had not provided R R1's hospital dischar indicated R1 was ar 11/1/20, at 1:38 p.m medical technician found at a hotel after R1 was admitted to as nursing home wi was gone from the While in the hospital assessment of capa During interview by a.m., hospital socia 11/1/20, R1 had to b	b been located yet and no e or family had been received. I lacked any further o R1's whereabouts. orts to the state agency (SA) 11/3/20, indicated an tarted when R1 was observed the facility. The facility 1 left the building while staff s and therefore not present in . R1 was assumed to have their wanderguard. Further, R1 bility to do so, and made a cility. int report to the SA, dated R1 was admitted to the hospital cility declined to take R1 back, cement difficulty. The facility 1 a discharge notice. arge summary dated 11/9/20, dmitted to the hospital at on n. accompanied by emergency (EMT) personnel. R1 was er eloping from Galtier Villa. hospital as vulnerable adult ill not take R1 back, since R1 facility for over 24 hours. al, psychiatry was consulted for	F	523	,			
	a vulnerable adult b take R1 back. SW-	because the facility would not						

If continuation sheet Page 5 of 9

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/14/2020 APPROVED 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTI	ICIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245340	B. WING				C 13/2020
NAME OF PROVIDER OF	₹ SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIER A VILLA CENTER					45 GALTIER AVENUE GAINT PAUL, MN 55103		
PREFIX (EACH	DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
SW-A star remain in that R1 w discharge nursing h different I unit. The guardians county. During inf a.m. fami R1 to hav issues. FI left the nu R1 was fo FM-A stat was able follow up since bee facility. During inf practical n R1 and hav LPN-A star redirectio LPN-A star redirectio LPN-A star stay changes after the e been resp notice.	since initia ted was n the hospi as not not or a bed ome decid ocation, a facility has ship paper terview by ly membe re mental M-A stated ursing hon bund at a ted had so to leave th from the f en dischar terview by nurse (LP ad been n ated R1 nd n, R1 was ated this h LPN-A st that would bonsible to to review on nistrator se d to the h	age 5 al admission in July 2020. tot in R1's best interest to ital. SW-A also had concerns tified of rights related to hold. Later, on 11/4/20, the ded to accept R1 back at a sister facility with a locked d requested hospital to start twork and submit it to the apphone on 11/12/20, at 11:20 or (FM)-A stated is typical for health problems and memory d had been updated that R1 ne when nobody was around. hotel and brought to a hospital. ome concerns over how R1 he facility and about lack of facility. FM-A stated R1 had ged and moved to a different apphone on 11/12/10, license N)-A stated was familiar with hotified the day R1 eloped. facility needed constant a "always trying to leave". had been the case for most of tated was unsure of any d prevent her coming back t. LPN-A stated would not have to issue a bed hold or discharge	F 6	23			

If continuation sheet Page 6 of 9

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/14/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245340	B. WING	i			C 13/2020
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIER A VILLA CENTER					445 GALTIER AVENUE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	hold notice would b administrator stated because they neede stated R1 had a lon- elopement, had trie wander. Subseque were to check the w function and monito DON stated since F from their facility, the locked unit. DON st responsible to issue rights to be informe Facility documentat and determined not the facility. The ass not provided. During interview on services director (S R1. SSD stated typis the hospital, social ask if they want the not done this becau and when SSD retur business day facilit admissions office d to return. SSD states the 30 day notice of transfer. During interview by pm, registered nurs with R1 and had be RN-A had initiated a resident including of wanderguard's to en placement. RN-A st	e completed. DON and d they could not take R1 back ed to be in a locked unit. DON ig history of being high risk for d in the past and would ntly, for most of R1's stay staff vanderguard on night shift for or its placement every shift. A1 had successfully eloped the hospital recommended a stated social services would be e notices related to resident d of discharge or transfer. tion that R1 was reassessed t to be able to come back to sessment was requested but 11/12/20 at 1:22 p.m. social SD) stated was familiar with ically when a resident goes to services would check in and ir bed hold. SSD stated had use R1 eloped on a weekend irned to work on the next ty management and the ecided R1 was not appropriate ed was unsure who would do f rights related to discharge or phone on 11/12/20, at 3:30 te (RN)-A stated was familiar en called the day R1 eloped. a check of all the current	F	623	3		

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		AND HUMAN SERVICES				FORM	12/14/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245340	B. WING				C 13/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIER A VILLA CENTER					45 GALTIER AVENUE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	RN-A stated would issuing a bed hold of During interview by a.m. admissions co- been involved in the AC-A stated the hos could be readmitted concern that R1 ha unsure R1's safety readmitted. AC-A si document this in the discussed as a tear During interview by a.m. R1 stated was moved from the hos home. R1 stated h paperwork from the discharge and trans During interview by p.m., administrator may have been lact the COVID-19 outb had been a safe wa have allowed her bas Facility policy Trans dated 11/28/20, ind who voluntarily or in from the facility will not be involuntarily circumstances meet regulations and law representative will r adequate preparation	not have been responsible for or discharge notice. phone on 11/13/20, at 9:13 oordinator (AC)-A stated had e readmissions consult for R1. spital had called to see if R1 d. AC-A stated there was a d eloped and they were could be maintained if tated was not responsible to e medical record, it was m. phone on 11/13/20, at 9:35 doing "ok" and had been spital to a different nursing ad not been provided any e facility related to her sfer. phone on 11/13/20, at 3:00 stated their documentation king because their focus was reak. The DON stated if there ay for R1 to return they would	F 6	23			
		e contains information about					

If continuation sheet Page 8 of 9

		AND HUMAN SERVICES				FORM	: 12/14/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245340	B. WING				C 13/2020
NAME OF	PROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GALTIEF	R A VILLA CENTER				145 GALTIER AVENUE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 623	the transfer and inf appeal rights. If the emergency, the not practicable. The fac discharge notices t	ormation about the resident's e transfer is due to an tice will be issued as soon as cility forwards a copy of all o the Office of the State mbudsman and required state	F	523			

Facility ID: 00480