Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 25, 2022

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

RE: CCN: 245340
Cycle Start Date: January 18, 2022

Dear Administrator:

On February 23, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Electronically delivered
January 27, 2022

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

RE: CCN: 245340
Cycle Start Date: January 18, 2022

Dear Administrator:

On January 18, 2022, 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"and/or an E tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 April 18, 2022 (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 July 18, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. BUILDING ______ B. WING ______	C 01/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/18/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5340118C (MN80023), with a deficiency cited at F600 and a related deficiency cited at F607. The following complaint was found to be UNSUBSTANTIATED: H5340117C (MN80130. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		2/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 02/04/2022

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

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F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 2 residents (R2 and R3) were free from abuse, the provider notified, and interventions identified after a physical altercation between R2 and R3 occurred. Findings include: Review of the 1/7/22, report to the SA identified a report was submitted at 9:37 p.m., identifying an unidentified nurse reported that two residents (R2 and R3) had an altercation. Both were alert and oriented and made a statement saying they had a "physical altercation". Staff were nearby however, no staff saw the physical altercation. A skin assessment was completed on both residents. No injuries were identified. Both residents were educated to avoid common areas. There was no mention in the report staff were educated to keep R2 and R3 apart or if increased supervision was required. Review of the 1/13/22, facility 5 day investigation report identified licensed practical nurse (LPN)-A stated she heard yelling at the elevator. R2 was trying to exit the elevator as R3 was attempting to get on. LPN-A heard R3 yelling "Don ' t you hit me!". R2 stated "Don ' t hit me!". LPN-A separated them immediately. LPN-A stated that R2 hit R3 and R3 stated R2 hit him first. LPN-A	F 600	R2 and R3 reside at Galtier, A Villa Center and remain without negative affects related to altercation. Residents that reside at Galtier, A Villa Center have the potential to be affected by this practice. Providers will be updated on all state agency reportable events. R2 and R3 were assessed and exhibited no affects. They have resumed their normal lifestyle. R2 and R3 care planned were submitted for appropriate changes to reflect resident condition. All Staff will be educated on the intervention on keeping R2 and R3 separated. Clinical Leadership has been educated on ensuring care plans are updated with any new interventions for any state agency reportable event and notifying staff of the intervention. All Nursing staff have been educated to update the MD/ NP regarding allegations of abuse. Administrator and Director of Nursing have been educated on using checklist for investigations. This will be used for any self- reports going forward to ensure all items are addressed. Administrator/designee will audit care	

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F 600	Continued From page 2 stated she did not witness the incident. Upon assessment, neither resident had any bruises or bleeding noted. Nurse aide (NA)-A stated she overheard "a guy saying she hit me", however had not witnessed the incident. R2 reported she was on the elevator with R3 going to the second floor. R2 was trying to get off the elevator and R3 was trying to get on. R3 struck R2 3-4 times. R3 reported R2 then slapped him on his right cheek. R3 stated R2 was being disrespectful and expressing "prejudice words". R3 remarked he only "retaliated" because of the prejudice words R2 allegedly said in the elevator said to him. Law enforcement was notified. There was no mention the facility identify interventions to ensure each resident's safety, nor was there any indication R2 or R3's care plans were updated or included specific interventions to prevent further abuse. R2's admission Minimum Data Set (MDS) dated 12/30/21, did not indicate R2's cognitive status and had not yet been completed at the time of survey. R2 had previous diagnoses of a stroke causing paralysis to R2's dominant, right side, a complete lesion (injury) to her lower spinal cord, and had difficulty speaking. R2's current, undated care plan indicated R1 had an alteration in communication, had limited physical mobility and required a wheelchair. The care plan did not reference the alleged physical abuse or indicate interventions to protect R2 from future occurrences or interactions with R3. During an interview on 1/18/22 11:13 a.m., R2 stated R3 was "bad" and hit her on her right shoulder and face, saying "you're slow" when R2 was attempting to exit the elevator. R2 stated she attempted to swing at R3 to protect herself with	F 600	plans interventions related to the allegation, audits will be completed to ensure MD/ NP are updated regarding allegation of abuse and audits will be completed to ensure checklist are being used for investigation. Audits will be conducted to ensure staff know the intervention for R2 and R3. Audits will be conducted 3X weekly for 2 weeks then monthly for 3 months, then reviewed at QAPI to determine the need for continued monitoring and compliance.	

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F 600	Continued From page 3 her left arm but was unable to reach him because he was on her paralyzed right side. R2 stated it was hard for her to move since having a stroke and she was often late for things. R2's speech was slurred and garbled, requiring her to repeat herself to be understood but was found to be an accurate historian. R3's significant change MDS dated 12/23/21, indicated R3 had no cognitive deficits. R3's current, undated care plan indicated R3 was known to "raise his voice" during disagreements with others. Staff were to intervene as necessary to protect the rights and safety of others and to monitor R3's behavior for yelling. The care plan lacked updated interventions for R3's recent episode of physical aggression towards R2. R3's Associated Clinic of Psychology (ACP) note dated 11/3/21, indicated R3 had had conflict with another resident, prior to the incident with R2, however R3 was unavailable for the appointment and no further information was provided. The note also indicated for staff to continue to monitor R3's impulsivity, irritability, and offer de-escalation to prevent provocation. R3's ACP note dated 12/1/21, indicated R3 had diagnoses of antisocial and narcissistic traits with anxious feature. During the assessment R3 admitted to being easily angered and frustrated during interactions with others. R3's current Order Summary indicated to monitor R3 for a targeted behavior of sleeplessness but lacked orders for monitoring R3's verbally or physically aggressive behaviors.	F 600		

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F 600	Continued From page 4 During an interview on 1/18/22, at 11:23 a.m. nursing assistant (NA)-B stated she was unaware of any conflict between residents recently. NA-B also stated she often worked on the unit but did not know who R3 was because he was transferred the day before from another floor. During an interview on 1/18/22, at 1:02 p.m. family member (FM)-A stated she was notified that R2 had had a "problem" with another resident recently while exiting the elevator, however, FM-A was not told of any other details regarding the incident and had not had a chance to talk to R2 since. During an interview on 1/18/22, at 2:04 p.m. registered nurse (RN)-A stated he was unaware of any conflicts between R2 and R3 and was not educated to any interventions to prevent further occurrences. During an interview on 1/18/22, at 2:09 p.m. nursing assistant (NA)-A stated she was assisting a resident in their room when NA-A overheard R3 say "she hit me" and R2 responded "no I didn't" in the hallway near the elevator. NA-A went to the hallway and found licensed practical nurse (LPN)-A intervening between R2 and R3 who were both exiting the elevator in their wheelchairs. R2 was on R3's left side, facing the same direction, with R2's right, paralyzed side closest to R3. During an interview on 1/18/22, at 3:30 p.m. RN-B stated although he was aware of R3's history of verbal aggression, RN-B was unaware of any care-planned interventions regarding R3's behaviors. RN-B had also not been notified of any conflict between R2 and R3, or the need to keep	F 600		

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F 600	Continued From page 5 them separated. During an interview on 1/18/22, at 3:39 p.m. RN-C stated she had not received any report of an incident between R2 and R3 and did not see anything in either resident's medical records to suggest there had been a physical confrontation between them or any intervention to keep them apart. During an interview on 1/1822, at 4:03 p.m. R3 stated he and R2 were in the elevator together when the doors opened on the second floor where R2 lived. R3 wheeled himself out of the elevator to let R2 out, but became frustrated when R2 wasn't moving fast enough. R3 was worried the elevator doors would close before he could get back in to go the the third floor where he lived at the time. R3 told R2 to move when R2 "started talking crazy to me" and words were exchanged. R3 admitted he struck R2 on her right side and "felt bad I put my hands on that woman." R3 also stated R2 was on his left and hit him with her right hand (although R2 was paralyzed on her right side). R3 stated the facility never told him to stay away from R2 but that he had "learned his lesson and it would not happen again". During an interview on 1/18/22, at 1:08 p.m. nurse practitioner (NP)-A stated she had not been notified of the incident between R2 and R3 that occurred on 1/11/22, and would have expected to be notified within a few days, even if there were no injuries to either resident. NP-A stated she was at the facility the previous day and had not been informed. NP-A stated R3 was recently moved to the second floor due to a positive COVID-19 test and, although R2 did not have	F 600		

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F 600	Continued From page 6 COVID-19 their rooms were now in the same hallway. NP-A stated that could be a concern to have R2 and R3 in the same hallway even though R3 was currently quarantined, and wondered if there was a better option. NP-A agreed interventions were need to be care planned, staff educated to the care plan, and appropriate supervision provided to ensure interventions were followed. During an interview on 1/18/22, at 4:15 p.m. the DON stated since R2 and R3 were cognitively intact, they were told to stay away from each other, and they both agreed. No further action was taken including staff education or updates to R2 and R3's care plans. The DON stated she believed the facility investigation revealed both R3 and R2 denied the event, therefore there was no need to monitor their behaviors. The DON also stated there was not a specific person assigned to notify NP-A of the event but that she was in the facility five days a week and believed she was told, but was unaware. During an interview on 1/18/22, at 4:41 p.m. the administrator stated although R2 and R3 were living on the same floor, R3 would be relocated back to the third floor after his quarantine period ended and there was no concern that he and R2 would have contact since he was in quarantine. Both residents were told to stay out of common areas at the same time and since they both agreed, no further interventions were implemented. The Administrator expected staff to notify each other of the alleged abuse during shift report and no other education or notification of the incident was done. Review of the 11/28/17, Abuse, Neglect,	F 600		

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F 600	Continued From page 7 Exploitation, Mistreatment and Misappropriation of Resident Property policy indicated residents would be protected from physical abuse (including hitting and slapping) while residing at the facility. Residents were to be monitored for protection and staff were to be educated in techniques to protect all residents. Facility leadership would assess the needs of the residents and identify concerns to prevent potential abuse. Safety and vulnerability assessments would be completed on each resident to identify potential vulnerabilities such as cognition, physical, psychosocial, environment, and communication. Resident vulnerabilities and interventions would be identified on a resident's care plan. The facility was to assess, monitor, and create a plan of care for residents who exhibit sensory and cognitive deficits, aggressive and/or socially inappropriate behaviors, and communication disorders.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 607	1. R2 and R3 remain at Galtier a Villa	2/15/22

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F 607	Continued From page 8 failed to ensure abuse and neglect policies were followed for timely reporting an allegation of abuse to the State Agency and implementation of policies after R2 was struck by R3. The facility also failed to ensure policies were reviewed and revised yearly to reflect current federal regulation for timely reporting of allegations of abuse and ensuring all staff were aware of any interventions and implement those needed interventions to keep the residents safe. Findings include: Review of the 1/7/22, report to the SA identified a report was submitted at 9:37 p.m., identifying an unidentified nurse reported that two residents (R2 and R3) had an altercation. Both were alert and oriented and made a statement saying they had a "physical altercation". Staff were nearby however, no staff saw the physical altercation. A skin assessment was completed on both residents. No injuries were identified. Both residents were educated to avoid common areas. There was no mention in the report staff were educated to keep R2 and R3 apart or if increased supervision was required. Review of the 1/13/22, facility 5 day investigation report identified licensed practical nurse (LPN)-A stated she heard yelling at the elevator. R2 was trying to exit the elevator as R3 was attempting to get on. LPN-A heard R3 yelling "Don ' t you hit me!". R2 stated "Don ' t hit me!". LPN-A separated them immediately. LPN-A stated that R2 hit R3 and R3 stated R2 hit him first. LPN-A stated she did not witness the incident. Upon assessment, neither resident had any bruises or bleeding noted. Nurse aide (NA)-A stated she overheard "a guy saying she hit me", however	F 607	Center and feel safe. Care Plan reviews were completed to ensure all appropriate interventions are current and in place. 2.Residents that reside at Galtier, A Villa Center have the potential to be affected by this practice. Allegations of abuse will be reported to the State Agency immediately, not to exceed 2 hours. Policy and Procedure for Abuse and neglect was reviewed and remains current. The Abuse and Neglect policy is reviewed annually. For future allegations of a abuse the facility will ensure immediate interventions are put in place to protect the resident. Abuse allegations will be reviewed at the monthly QAPI for trends to prevent further potential deficiencies. 3. Staff in all departments have been educated on the definition of abuse, reporting timeframe, and reporting to the supervisor immediately. Education has been completed to ensure the safety of the residents and implementation of immediate interventions after an allegation has been made to avoid future situations. 5. Administrator/designee will audit all allegations and ensure that they are reported with the appropriate time frame and that immediate interventions are put in place to protect the resident. Audits will conduct for three times weekly for 2 weeks and then monthly for 3 months, then reviewed at QAPI to determine the need for continued monitoring and compliance.	

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

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F 607	Continued From page 9	F 607	Completion Date: 2/15/2022	

had not witnessed the incident. R2 reported she was on the elevator with R3 going to the second floor. R2 was trying to get off the elevator and R3 was trying to get on. R3 struck R2 3-4 times. R3 reported R2 then slapped him on his right cheek. R3 stated R2 was being disrespectful and expressing "prejudice words". R3 remarked he only "retaliated" because of the prejudice words R2 allegedly said in the elevator said to him. Law enforcement was notified. There was no mention the facility identify interventions to ensure each resident's safety, nor was there any indication R2 or R3's care plans were updated or included specific interventions to prevent further abuse.

R2's admission Minimum Data Set (MDS) dated 12/30/21, did not indicate R2's cognitive status and had not yet been completed at the time of survey. R2 had previous diagnoses of a stroke causing paralysis to R2's dominant, right side, a complete lesion (injury) to her lower spinal cord, and had difficulty speaking.

R2's current, undated care plan indicated R1 had an alteration in communication, had limited physical mobility and required a wheelchair. The care plan did not reference the alleged physical abuse or indicate interventions to protect R2 from future occurrences or interactions with R3.

During an interview on 1/18/22 11:13 a.m., R2 stated R3 was "bad" and hit her on her right shoulder and face, saying "you're slow" when R2 was attempting to exit the elevator. R2 stated she attempted to swing at R3 to protect herself with her left arm but was unable to reach him because he was on her paralyzed right side. R2 stated it was hard for her to move since having a stroke and she was often late for things. R2's speech

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F 607	Continued From page 10	F 607		

was slurred and garbled, requiring her to repeat herself to be understood but was found to be an accurate historian.

R3's significant change MDS dated 12/23/21, indicated R3 had no cognitive deficits.

R3's current, undated care plan indicated R3 was known to "raise his voice" during disagreements with others. Staff were to intervene as necessary to protect the rights and safety of others and to monitor R3's behavior for yelling. The care plan lacked updated interventions for R3's recent episode of physical aggression towards R2.

R3's Associated Clinic of Psychology (ACP) note dated 11/3/21, indicated R3 had had conflict with another resident, prior to the incident with R2, however R3 was unavailable for the appointment and no further information was provided. The note also indicated for staff to continue to monitor R3's impulsivity, irritability, and offer de-escalation to prevent provocation.

R3's ACP note dated 12/1/21, indicated R3 had diagnoses of antisocial and narcissistic traits with anxious feature. During the assessment R3 admitted to being easily angered and frustrated during interactions with others.

R3's current Order Summary indicated to monitor R3 for a targeted behavior of sleeplessness but lacked orders for monitoring R3's verbally or physically aggressive behaviors.

During an interview on 1/18/22, at 11:23 a.m. nursing assistant (NA)-B stated she was unaware of any conflict between residents recently. NA-B also stated she often worked on the unit but did

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F 607	Continued From page 11 not know who R3 was because he was transferred the day before from another floor. During an interview on 1/18/22, at 1:02 p.m. family member (FM)-A stated she was notified that R2 had had a "problem" with another resident recently while exiting the elevator, however, FM-A was not told of any other details regarding the incident and had not had a chance to talk to R2 since. During an interview on 1/18/22, at 2:04 p.m. registered nurse (RN)-A stated he was unaware of any conflicts between R2 and R3 and was not educated to any interventions to prevent further occurrences. During an interview on 1/18/22, at 2:09 p.m. nursing assistant (NA)-A stated she was assisting a resident in their room when NA-A overheard R3 say "she hit me" and R2 responded "no I didn't" in the hallway near the elevator. NA-A went to the hallway and found licensed practical nurse (LPN)-A intervening between R2 and R3 who were both exiting the elevator in their wheelchairs. R2 was on R3's left side, facing the same direction, with R2's right, paralyzed side closest to R3. During an interview on 1/18/22, at 3:30 p.m. RN-B stated although he was aware of R3's history of verbal aggression, RN-B was unaware of any care-planned interventions regarding R3's behaviors. RN-B had also not been notified of any conflict between R2 and R3, or the need to keep them separated. During an interview on 1/18/22, at 3:39 p.m. RN-C stated she had not received any report of	F 607		

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an incident between R2 and R3 and did not see anything in either resident's medical records to suggest there had been a physical confrontation between them or any intervention to keep them apart.

During an interview on 1/1822, at 4:03 p.m. R3 stated he and R2 were in the elevator together when the doors opened on the second floor where R2 lived. R3 wheeled himself out of the elevator to let R2 out, but became frustrated when R2 wasn't moving fast enough. R3 was worried the elevator doors would close before he could get back in to go the the third floor where he lived at the time. R3 told R2 to move when R2 "started talking crazy to me" and words were exchanged. R3 admitted he struck R2 on her right side and "felt bad I put my hands on that woman." R3 also stated R2 was on his left and hit him with her right hand (although R2 was paralyzed on her right side). R3 stated the facility never told him to stay away from R2 but that he had "learned his lesson and it would not happen again".

During an interview on 1/18/22, at 1:08 p.m. nurse practitioner (NP)-A stated she had not been notified of the incident between R2 and R3 that occurred on 1/11/22, and would have expected to be notified within a few days, even if there were no injuries to either resident. NP-A stated she was at the facility the previous day and had not been informed. NP-A stated R3 was recently moved to the second floor due to a positive COVID-19 test and, although R2 did not have COVID-19 their rooms were now in the same hallway. NP-A stated that could be a concern to have R2 and R3 in the same hallway even though R3 was currently quarantined, and wondered if

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there was a better option. NP-A agreed interventions were need to be care planned, staff educated to the care plan, and appropriate supervision provided to ensure interventions were followed.

During an interview on 1/18/22, at 4:15 p.m. the DON stated since R2 and R3 were cognitively intact, they were told to stay away from each other, and they both agreed. No further action was taken including staff education or updates to R2 and R3's care plans. The DON stated she believed the facility investigation revealed both R3 and R2 denied the event, therefore there was no need to monitor their behaviors. The DON also stated there was not a specific person assigned to notify NP-A of the event but that she was in the facility five days a week and believed she was told, but was unaware. Any abuse or neglect allegation should have been reported to her or the Administrator immediately, no matter what time of day, and only the DON or Administrator report to the SA although that was not reflected in their current abuse reporting policy.

During an interview on 1/18/22, at 4: 41 p.m. the Administrator stated she notified the SA as soon as she was told about the allegation of abuse around 9:30 p.m. although the incident had occurred around 5:45 p.m. The Administrator stated staff were expected to report any allegations of abuse to her immediately. The Administrator also stated there was no documentation to support re-education was done with staff regarding the late reporting of the alleged abuse between R2 and R3 to the administrator who was responsible to submit the report to the SA. Although R2 and R3 were living on the same floor, R3 would be relocated back to

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F 607	Continued From page 14	F 607		

the third floor after his quarantine period ended and there was no concern that he and R2 would have contact since he was in quarantine. Both residents were told to stay out of common areas at the same time and since they both agreed, no further interventions were identified and care plans were not updated. The Administrator expected staff to notify each other of the alleged abuse during shift report and no other education or notification of the incident was done.

Review of the 11/28/17, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy identified immediately upon receiving a report of alleged abuse, the administrator and or designee was to coordinate the delivery of appropriate medical and/or psychosocial care and attention. Staff were to ensure the safety and wellbeing of the resident and roommate if applicable, and other residents who have the potential to be affected. Staff were to remove the resident alleged to have caused the abuse from the situation and wait for further instruction from the administrator if possible. Staff were to assess and interview the resident affected and interview other residents who may be affected to determine injury and identify immediate interventions. Staff were to notify the resident's physician. If a resident could be at risk in the same environment, staff were to evaluate the situation and consider a potential room or roommate change. Staff were to notify the SA "as indicated". If an injury was inexplicable, abuse and caregiver neglect substantiated, or a therapeutic error resulted in an injury, the policy noted a report was to be made to the SA within 24 hours of the intial findings. Allegations of abuse that did not result in serious bodily injury were also to be reported no later than 24 hours. There

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F 607	Continued From page 15 was no mention the facility had reviewed and/or revised the policy annually to ensure it met the federal reporting requirements to report to the SA immediately or within 2 hours for all allegations of abuse.	F 607		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 27, 2022

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

Re: Event ID: FQUP11

Dear Administrator:

The above facility survey was completed on January 18, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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	00480	A. BUILDING: ______ B. WING ______	C 01/18/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/18/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/04/22

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5340118C (MN80023), however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5340117C (MN80130. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		