DEPARTMENT OF HEALTH AND HUMAN SERV			DICARE & MEDICAID SERVICES
	EDICAID CERTIFICATION A COMPLETED BY THE STAT		ID: 0QGF Facility ID: 00522
(L1) 245267 (L3) ST 2.STATE VENDOR OR MEDICAID NO. (L4) 37 0	IE AND ADDRESS OF FACILITY ANTHONY HEALTH & REHAB 00 FOSS ROAD NORTHEAST ANTHONY, MN	EILITATION (L6) 55421	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PRC (L9) 01 Hosp 6. DATE OF SURVEY 12/12/2017 (L34)		<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint
0 Unaccredited 1 TJC 04 SNF 2 AOA 3 Other	NF/Distinct 07 X-Ray 11 ICF/IID 08 OPT/SP 12 RHC	0 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
From (a): X A. To (b):	FACILITY IS CERTIFIED AS: In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of 7 2. Technical Personnel 3. 24 Hour RN	The Following Requirements: 6. Scope of Services Limit 7. Medical Director
	1. Acceptable POC lot in Compliance with Program quirements and/or Applied Waivers:	4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A*	 F)8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF 140	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHO	OW LTC CANCELLATION DATE):		
See Attached Remarks	_		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	
Gloria Derfus, Unit Supervisor	01/16/2018 (L19)	Mark Meath, 1	Enforcement Specialist 01/16/2018 (L20)
PART II - TO BE COMPI	LETED BY HCFA REGIONAL	LOFFICE OR SINGLE S	FATE AGENCY
 DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		icial Solvency (HCFA-2572) l Interest Disclosure Stmt (HCFA-1513) :
2. Facility is not Eligible (L21)			
22. ORIGINAL DATE23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING DATE 07/01/1984	ENDING DATE	VOLUNTARY 00 01-Merger, Closure 0	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination	
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANC A. Suspension of Admis	sions:	04-Other Reason for Withdrawal	" <u>OTHER</u> 07-Provider Status Change 00-Active
(L27) B. Rescind Suspension	(L44) Date:		00-100100
	(L45)		
28. TERMINATION DATE: 29. INTERN	MEDIARY/CARRIER NO.	30. REMARKS	
	001		
(L28)	(L31)		

(L33)

DETERMINATION APPROVAL

12/18/2017

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDI	ICAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: 0QGF
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00522

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5267

Based on review of the facility's plan of correction, the facility is back in compliance with the Federal requirements identified as deficient at the time of their recertification survey exited October 27, 2017. In addition, compliance was determined for the complaint investigation number H5267081.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245267

January 16, 2018

Ms. Claire Carpenter, Administrator St Anthony Health & Rehabilitation 3700 Foss Road Northeast St Anthony, MN 55421

Dear Ms. Carpenter:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 6, 2017 the above facility is certified for:

140 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 140 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



Electronically delivered January 16, 2018

Ms. Claire Carpenter, Administrator St Anthony Health & Rehabilitation 3700 Foss Road Northeast St Anthony, MN 55421

RE: Project Number S5267020 and H5267081

Dear Ms. Carpenter:

On November 15, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 27, 2017 that included an investigation of complaint number H5267081. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On December 12, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 6, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 27, 2017, effective December 6, 2017 and therefore remedies outlined in our letter to you dated November 15, 2017, will not be imposed.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH A			CEDTIEIC		CENTERS FOR ME	DICARE & MEDI	
					TE SURVEY AGENCY		ID: 0QGF Facility ID: 00522
 MEDICARE/MEDICAID PROVIDER N (L1) 245267 STATE VENDOR OR MEDICAID NO. (L2) 369742800 		3. NAME AND AD (L3) ST ANTHON (L4) 3700 FOSS F (L5) ST ANTHON	DRESS OF FAC NY HEALTH & ROAD NORTH	CILITY & REHAB		4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	
•	 40 (L18) 40 (L18) 40 (L17) 19 SNF (L39) 	X B. Not in Com Requirements ICF (L42)	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP TIS CERTIFIED nce With equirements Based On: cceptable POC and/or Applied V IID (L43)	09 ESRD 10 NF 11 ICF/IID 12 RHC AS: AS:	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE 2. Technical Personnel 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	1 6. Scope of S 7. Medical D	ING DATE: (L35) nents: Services Limit birector om Size
See Attached Remarks	,			,			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Sheila Placido, HFE NEII		1	1/27/2017	(L19)	Mark Meath	, Enforcement Spe	cialist 12/18/2017 (L20)
PART I	I - TO BE	COMPLETED B	BY HCFA RE	GIONAI	OFFICE OR SINGLE S	STATE AGENCY	
 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Partici 2. Facility is not Eligible 	pate (L21)		PLIANCE WITH ITS ACT:	I CIVIL	 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov 	ol Interest Disclosure Stm	
22. ORIGINAL DATE 23	. LTC AGREEN	MENT 24	LTC AGREEN	1ENT	26. TERMINATION ACTION	[:	(L30)
OF PARTICIPATION 07/01/1984	BEGINNING	DATE	ENDING DAT	ГЕ	VOLUNTARY 0 01-Merger, Closure		<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE: 27. (L27)	A. Suspension	VE SANCTIONS a of Admissions: aspension Date:	(L44) (L45)		03-Risk of Involuntary Termination	OTHER	der Status Change e
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
((L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDI	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: 0QGF
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00522

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN: 24 5267

A standard survey was completed at this facility by the Departments of Health and Public Safety. An investigation of complaint H5267080 was completed and was not substantiated and an investigation of complaint H5267081 was completed and was substantiated at F164, F225, and F226. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 15, 2017

Ms. Claire Carpenter, Administrator St. Anthony Health & Rehabilitation 3700 Foss Road Northeast St. Anthony, MN 55421

RE: Project Numbers S5267020, H5267080, H5267081

Dear Ms. Carpenter:

On October 27, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 27, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5267080 that was found to be unsubstantiated and an investigation of complaint H5267081 that was found to be substantiated at F164, F225 and F226. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit; <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: gloria.derfus@state.mn.us Phone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 6, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

St. Anthony Health & Rehabilitation November 15, 2017 Page 4

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 27, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 27, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

St. Anthony Health & Rehabilitation November 15, 2017 Page 6

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

	-	& MEDICAID SERVICES			0		APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE CC	DNSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			IPLETED C
		245267	B. WING				/ 27/2017
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION			FOSS ROAD NORTHEAST NTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00			
	recertification surve from the Minnesota to determine compl	, 25, 26 and 27, 2017, a ey was completed by surveyors Department of Health (MDH) iance with requirements at 42 part B, requirements for Long s.					
		onic Plan of Correction (ePoC) llegation of compliance upon cceptance.					
	is not required at th the CMS-2567 form	nrolled in ePoC, your signature e bottom of the first page of n. Your electronic submission sed as verification of					
F 156 SS=D	completed at the tir substantiated at F1 investigation of com completed and was NOTICE OF RIGHT CHARGES	complaint H5267081 was ne of the survey and was 64, F225, and F226. An pplaint H5267080 was not substantiated. TS, RULES, SERVICES, 3)(g)(1)(4)(5)(13)(16)-(18)	F 1:	56			12/6/17
	remains informed o of contacting the ph	ust ensure that each resident of the name, specialty, and way hysician and other primary care onsible for his or her care.					
	(1) The resident hat his or her rights and	tion and Communication. s the right to be informed of d of all rules and regulations conduct and responsibilities ay in the facility.					
	r director's or provid	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	I	TITLE		(X6) DATE 11/21/2017

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.

DEDADTMENT OF LIEALTH AND LIUMAN CEDVICES

		AND HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES							0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			(C
		245267	B. WING			10/:	27/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION		-	8700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 156	Continued From pa	ge 1	F 1	56			
	(a)(4) The resident	has the right to receive					
		ning spoken) and in writing					
	(including Braille) in or she understands	a format and a language he , including:					
	(i) Required notices	as specified in this section.					
	The facility must fur	nish to each resident a written rights which includes -					
		the manner of protecting ler paragraph (f)(10) of this					
	procedures for esta including the right to	the requirements and blishing eligibility for Medicaid, o request an assessment of ction 1924(c) of the Social					
	email), and telephon State regulatory and resident advocacy of Survey Agency, the State Long-Term Ca protection and advo services where stat in long-term care fa agency for informat	addresses (mailing and ne numbers of all pertinent d informational agencies, groups such as the State State licensure office, the are Ombudsman program, the ocacy agency, adult protective e law provides for jurisdiction cilities, the local contact ion about returning to the Medicaid Fraud Control Unit;					
	complaint with the S concerning any sus	t the resident may file a State Survey Agency pected violation of state or lity regulations, including but ent abuse, neglect,					

If continuation sheet Page 2 of 66

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:			· · · · · · · ·		PLETED
		245267	B. WING			С	
	PROVIDER OR SUPPLIER	243207	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	10/2	27/2017
					3700 FOSS ROAD NORTHEAST		
ST ANTH	IONY HEALTH & REH	ABILITATION		S	ST ANTHONY, MN 55421		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
					DEFICIENCY)		
F 156	Continued From no	ao 0		- 0			
1 150	Continued From pa	ge 2 propriation of resident property	F 1	56	,		
		ompliance with the advance					
	directives requirem	ents and requests for					
	information regardin	ng returning to the community.					
	(ii) Information and	contact information for State					
		organizations including but					
		ate Survey Agency, the State mbudsman program					
		section 712 of the Older					
		965, as amended 2016 (42					
) and the protection and as designated by the state, and					
		er the Developmental					
		nce and Bill of Rights Act of					
	2000 (42 U.S.C. 15	ill be implemented beginning					
	November 28, 2017						
	(iii) Information road	arding Medicare and Medicaid					
	eligibility and covera						
	[§483.10(g)(4)(iii) w	rill be implemented beginning					
	November 28, 2017	7 (Phase 2)]					
	(iv) Contact informa	ation for the Aging and					
		Center (established under					
		B)(iii) of the Older Americans rong Door Program;					
		vill be implemented beginning					
	November 28, 2017						
	(v) Contact informa	tion for the Medicaid Fraud					
	Control Unit; and						
		ill be implemented beginning					
	November 28, 2017	r (Phase 2)]					
		contact information for filing					
	grievances or comp	plaints concerning any					

If continuation sheet Page 3 of 66

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245267	B. WING		10	C / 27/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (/21/2011
ST ANTI	HONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 156	suspected violation facility regulations, resident abuse, neg misappropriation of facility, non-complia directives requirem information regardin (g)(5) The facility m manner accessible residents, resident (i) A list of names, a and telephone num agencies and advor Survey Agency, the protective services jurisdiction in long-t of the State Long-T program, the protect home and commun and the Medicaid F (ii) A statement that complaint with the S concerning any sus federal nursing faci limited to resident a misappropriation of facility, and non-con directives requirem I) and requests for to the community. (g)(13) The facility n written information, applicants for admis	of state or federal nursing including but not limited to glect, exploitation, resident property in the ance with the advance ents and requests for ng returning to the community. ust post, in a form and and understandable to		56		

If continuation sheet Page 4 of 66

		AND HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1)			()(0) MI II 7				0938-0391
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					E SURVEY IPLETED
			A. BOILDI	NG.			С
		245267	B. WING _				
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	IONY HEALTH & REH			3	700 FOSS ROAD NORTHEAST		
STANT		ABILITATION		S	ST ANTHONY, MN 55421		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
1.1.5		· · · · · · · · · · · · · · · · · · ·			DEFICIENCY)		
F 156	Continued From pa	ige 4	F 1	56			
		caid benefits, and how to					
		previous payments covered by					
	such benefits.						
	(a)(16) The facility r	must provide a notice of rights					
		resident prior to or upon					
	admission and duri	ng the resident's stay.					
	(i) The facility must	inform the resident both orally					
		inform the resident both orally anguage that the resident					
		or her rights and all rules and					
	regulations governing	ng resident conduct and					
	responsibilities duri	ng the stay in the facility.					
	(ii) The facility must	t also provide the resident with					
		d notice of Medicaid rights and					
	obligations, if any.						
		information, and any must be acknowledged in					
	writing;	Ilust be acknowledged in					
	, , , , , , , , , , , , , , , , , , ,						
	(g)(17) The facility r	nust					
	(i) Inform each Mec	dicaid-eligible resident, in					
		of admission to the nursing					
		e resident becomes eligible for					
	Medicaid of-						
	(A) The items and s	services that are included in					
		ices under the State plan and					
	for which the reside	ent may not be charged;					
	(B) Those other iter	ms and services that the					
		or which the resident may be					
		mount of charges for those					
	services; and						

Facility ID: 00522

If continuation sheet Page 5 of 66

		AND HUMAN SERVICES				FORM	: 11/27/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245267	B. WING	i			C 27/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION			700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	 (ii) Inform each Med changes are made specified in paragra this section. (g)(18) The facility r before, or at the tim periodically during t available in the facil services, including a covered under Med facility's per diem rat (i) Where changes is and services covered Medicaid State plan notice to residents of reasonably possible (ii) Where changes items and services facility must inform 60 days prior to imp (iii) If a resident dies transferred and doe facility must refund representative, or e deposit or charges a per diem rate, for th resided or reserved facility, regardless of discharge notice ref (iv) The facility must resident representative 	dicaid-eligible resident when to the items and services aphs (g)(17)(i)(A) and (B) of must inform each resident the of admission, and the resident's stay, of services lity and of charges for those any charges for services not licare/ Medicaid or by the ate. in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e. are made to charges for other that the facility offers, the the resident in writing at least olementation of the change. s or is hospitalized or is es not return to the facility, the to the resident, resident estate, as applicable, any already paid, less the facility's ne days the resident actually d or retained a bed in the of any minimum stay or quirements. et refund to the resident or tive any and all refunds due 30 days from the resident's	F	156			

		AND HUMAN SERVICES			F	ORM /	11/27/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X		SURVEY PLETED
		245267	B. WING				, 27/2017
NAME OF I	PROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION			700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156	Continued From pa	ige 6	F 1	56			
	behalf of an individu facility must not corr these regulations. This REQUIREMEN by: Based on interview facility failed to providiscontinuation of s (R7, R8) who rema Medicare covered s Findings include: R8 received a Notic dated 1/24/17, for a 1/26/17. R8 remain Medicare days rem determination of co R8 received a Notic but refused to sign, 7/24/17. R8 remain Medicare days rem determination of co worker (LSW)-A sta Medicare Non-Cove there was no docur Medicare Non-Cove R7 received a Notic dated 10/5/17, for a 10/7/17. R7 remain Medicare days rem determination of co	ce of Medicare Non-Coverage a coverage end date of ed in the facility, with 79 aining but did not receive a ntinued stay. ce of Medicare Non-Coverage for a coverage end date of ed in the facility, with 80 aining but did not receive a ntinued stay. Licensed social ated R8 was given notice of erage on 7/21/17, but verified nentation of notice of erage. ce of Medicare Non-Coverage a coverage end date of ed in the facility, with 59 aining but did not receive a			St. Anthony Health & Rehabilitation (SAHR) makes its best effort to opera full compliance with state and federal law. Nothing included in ti plan of correction is an admission otherwise. SAHR has submitted this plan of correction is order to comply with its regulatory obligation and does not waive any objections to the merits form of any allegations contained her Please note that SAHR may contest the merits an form of any of the deficiency findings alleged below and may take reasonable steps to ap them. Please accept this plan of correction as SAHR's allegation of substantial compliance. F156 Notice of Rights, Rules, Services, Charges 1. R7 remains in the facility. R8 has been discharged, 2. The appropriate Notice of Medica Non-Coverage forms have been initia 3. The facility has developed a Med Notice procedure. 4. The facility MDS coordinators and	his in s or ein. nd/or opeal opeal are ated. licare	

Facility ID: 00522

	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
				3		С	
		245267	B. WING			27/2017	
	PROVIDER OR SUPPLIER	IABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 156	Medicare days rem determination of co During an interview LSW-A stated the M Coordinator provide Medicare Non-Cove that the MDS Coord a form to issue to re make sure they kno LSW-A verified they CMS 10123) and the from Humana if app During an interview MDS Coordinator vo one letter and did in 10055 or other app facility) denial letter During an interview administrator stated Medicare recipients liability notices whe had not exhausted administrator stated than one type of no resident or resident expect the MDS Co the correct notice. I team asked for den which the facility ind and found during the called it an appeal	ined in the facility, with 52 aining but did not receive a ontinued stay. on 10/27/17, at 7:45 a.m., Minimum Data Set (MDS) ed education on the Notice of erage. LSW-A further indicated dinator gave the social workers esidents and/or families and by they have a right to appeal. y only gave one form (Form hey also gave a denial letter plicable to the resident. on 10/27/17, at 9:38 a.m., the rerified they were only issuing to know about Form CMS ropriate SNF (skilled nursing 's. on 10/27/17, at 2:54 p.m., the d she was "not aware" that s were not receiving both in they stayed in the facility and their benefits. In addition, the d she was not aware that more tice was to be given to the t's representative and would bordinators and LSW's to give Lastly, upon entrance, survey nand bills from the facility and dicated they did not have any he investigation that the facility rather than demand bill. The d she was not aware that these	F 15	 Social Workers have been in the Medicare Notice proceds Facility leadership will and coverage notice per week for notice until the next facility C on 12/19/17. The facility QA&A common review completed audit result further recommendations. The Executive Director of responsible for compliance of requirement, to ensure each receives notice of changes in the second second	ure. udit 1 end of or appropriate QAPI meeting nittee will Its and make remains with this o resident		

SURVEY ETED
/2017
,
(X5) COMPLETION DATE
2/6/17

If continuation sheet Page 9 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM A	11/27/2017 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3)	(X3) DATE SURVEY COMPLETED		
		245267	B. WING	i		C 10/27/2017		
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	ABILITATION			700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 164	law enforcement pupurposes, research medical examiners, a serious threat to here a serious the facility for resident's personal of 5 residents (R83 dependent upon state). The series a serious the series a	on 10/25/17, at 1:38 p.m. NA)-B stood R150 utilizing the e bathroom. There were two the back of the resident's Between her and [R83], I don't mould swear these two day and take water pills."	F	164	 F164 Privacy 1. The identified resident R83 has has her care plans and NAR assignment sheets reviewed and updated as need to include providing for privacy and dignity. 2. The responsible staff were re-educated on privacy and dignity as soon as notified of the concern during annual survey. 3. Staff will be re-trained on providing resident privacy and dignity using spect examples cited in the CMS-2567. 4. Nursing leadership will assess privand dignity competency on 6 staff members a week until all nursing staff have been assessed. 5. Nursing leadership will also look a potential privacy and dignity issues wh completing various scheduled audits s as med pass audits, NAR direct care audits, toileting, etc. 6. The Director of Nursing will review completed audits and bring any identif privacy concerns to the facility QAPI committee for review and further recommendations. 7. The Director of Nursing remains responsible for compliance with this requirement to ensure residents the right of the sector of the	ded I the g for cific vacy f at nile such v the fied		

Facility ID: 00522

If continuation sheet Page 10 of 66

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
		245267	B. WING		C 10/27/	
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		/21/2011
ST ANTH	IONY HEALTH & REH	IABILITATION	:			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 164	with all ADLs and F of bladder and bow During interview on verified making the	33 required extensive assist 883 was frequently incontinent	F 164	to personal privacy and confide 8. See also F241	ntiality.	
	stated she thought information to expla changed every two more often. RN-C of waited to explain th providing R150's ca	10/25/17, at 2:22 p.m. RN-C NA-B was trying to provide ain that all residents were hours and R83 was changed confirmed NA-B should have hat until they were done are.				
	stated staff "should	I be focused on the resident ith and not talk about any other				
	director of nursing	10/26/17, at 2:32 p.m. the verified the staff should not 3 while providing care to				
F 176 SS=D	included: "Staff will information in locat conversations may persons, such as o RESIDENT SELF-/	be overheard by unauthorized ther clients or visitors." ADMINISTER DRUGS IF	F 176			12/6/17

Facility ID: 00522

If continuation sheet Page 11 of 66

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ((X3) DATE	0938-039 SURVEY PLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING		(
		245267	B. WING			10/27/2017		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	ABILITATION	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 176		-	F 1	76				
	practice is clinically	as determined that this appropriate. NT is not met as evidenced						
	Based on observatively for the self-administration of 1 resident (R18 determined it was self-administration of 1 of 1 resident (R18 determined it was self-administration of 1 of 1 resident (R18 determined it was self-administration of 1 of 1 resident (R18 determined it was self-administration) and an Ventoli open the airway) waresident's nightstand R186 was interview R186 said she kept and used it when self and order for the Ver hours as needed for included, ""may lear medication administ Review of R186's self self self self self self self sel	of medications was allowed for 36) only after an assessment safe. bserved on 10/24/17, at 10:16 in inhaler (medication used to as observed on top of the id available for use. red on 10/24/17, at 10:45 a.m. t the inhaler on her nightstand he needed it. the Sheet on R186's record been admitted 5/28/15, with a ded chronic obstructive Orders dated 5/29/16, included ntolin to be used every four or shortness of breath and ve at bedside for SAM (self-			 F176 Resident Self Administer Drugs 1. R186 has had a self administratimedications assessment completed care plans updated as needed. 2. A self-administration of medicatiassessment has been completed or other residents wishing to self-adminimedications at the bedside. 3. Staff will be re-educated on the for accurate completion of a self-administration of medication for resident that wishes to self-administimedications. 4. Nursing leadership will assess medication administration competer 5 nurses per week until all Nurses h been assessed. 5. Nursing leadership will audit the accuracy of the self administration of medication of medications assessment with each quarterly, annual, or significant char condition MDS. 6. The audits will be reviewed and identified concerns will be brought to facility QAPI committee for further recommendations. 7. The Director of Nursing remains responsible to ensure residents are assessed for the ability to self-administrations. 	I with ions n any nister need r any er ncy for ave of any o the		
	On 10/24/17, at 10:	19 a.m. registered nurse-F an order to leave the			medications.			

Facility ID: 00522

		AND HUMAN SERVICES				FORM	: 11/27/2017 APPROVED . 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	CON	E SURVEY IPLETED
		245267	B. WING				27/2017
NAME OF F	PROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 176	Continued From pa	-	F 1	176	;		
	medication at the b to self-administer the	edside, but was not assessed					
F 225 SS=D	INVESTIGATE/REF ALLEGATIONS/INI CFR(s): 483.12(a)(PORT DIVIDUALS	F 2	225			12/6/17
	483.12(a) The facili						
	(3) Not employ or o who-	therwise engage individuals					
		d guilty of abuse, neglect, propriation of property, or court of law;					
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or					
	or her professional body as a result of	ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.					
	licensing authorities actions by a court c	ate nurse aide registry or s any knowledge it has of of law against an employee, te unfitness for service as a facility staff.					
		Illegations of abuse, neglect, treatment, the facility must:					
	abuse, neglect, exp	alleged violations involving ploitation or mistreatment, unknown source and					

If continuation sheet Page 13 of 66

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM. CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.							
							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
			A. DOILDI	<u> </u>		C	2
		245267	B. WING _				27/2017
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	FHABILITATION		-	700 FOSS ROAD NORTHEAST		
••••				S	T ANTHONY, MN 55421		
(X4) ID		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPF		DATE
					DEFICIENCY)		
F 005							
F 225		-	F 22	25			
		resident property, are					
		ly, but not later than 2 hours is made, if the events that					
		n involve abuse or result in					
	serious bodily injury	, or not later than 24 hours if					
		se the allegation do not involve					
		esult in serious bodily injury, to					
		o the State Survey Agency and					
	adult protective service	vices where state law provides					
		ng-term care facilities) in					
		ate law through established					
	procedures.						
		that all alleged violations are					
	thoroughly investiga	ated.					
	(3) Prevent further	potential abuse, neglect,					
	exploitation, or mist	reatment while the					
	investigation is in pr	rogress.					
	(4) Report the resul	Its of all investigations to the					
	administrator or his						
	representative and	to other officials in accordance					
		Iding to the State Survey					
		orking days of the incident, and					
	corrective action mi	on is verified appropriate					
		NT is not met as evidenced					
	by:						
		and document review, the			F225		
		rationalize their abuse r 1 of 1 resident (R31), who			Abuse reporting and investigating		
		e with derogatory comments			1. The allegation of abuse by R31	has	
		dition, the facility failed to			been reported and investigated. The		
	ensure a bruise of u	unknown origin located on a			bruise for R150 has been investigat	ted.	
		s reported to the State agency			2. The facility Vulnerable Adult Ab		
	(SA) in a timely mai (R150).	nner for 1 of 1 resident			Prevention policy and procedure ha reviewed and remains appropriate.	s been	

Facility ID: 00522

If continuation sheet Page 14 of 66

		AND HUMAN SERVICES				FORM	11/27/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/27/2017 IP CODE	
		245267	B. WING _				
NAME OF F	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 14	F 22				
	Face Sheet in the r diagnoses including compression fractu- muscle weakness, stroke. During an interview p.m. R31 stated sh that nursing assista her when she calle R31 stated "[NA-G] you because you're had reported the in working that night. R31's care plan da explain cares and p offer validation of fe chart "prefers male prevention, monitor accusations of abu report all signs and neglect. Staff to as	to the facility on 3/24/17. The resident's record indicated g: spinal stenosis of neck, ire of first lumbar vertebra, diabetes, and history of v with R31 on 10/24/17, at 1:18 he had "complained to a nurse ant (NA)-[G] emotionally hurt d her the devil about 20 times."] said nobody out here likes the devil." R31 stated she cident to the nurse who was ted 7/26/17, directed staff to procedures prior to performing, eelings, social service note in a care givers", abuse r for all signs and symptoms, se or neglect. Investigate and I symptoms of abuse or sist resident out of dining room g into or altercations with other			 The Administrator and DON att VAA education at Care Providers jot training on 11/7/17. Staff have been re-educated of facility Vulnerable Adult Abuse Prev policy and program. The IDT will review each incide determine if reportable and approp preventative measures are put in p The facility QAPI committee wi review all incidents monthly. See also F226. The Executive Director remains responsible for compliance with this requirement, to ensure that all alleg violations involving mistreatment, nor abuse, including injuries of unkn source are reported immediately 	oint n the vention ent to riate lace. Il s s ged ueglect,	
	residents. The Cog care plan indicated assessed, care pla deemed appropriat (IDT). The undated indicated R31 prefe On 9/27/17, R31's (MDS) assessment cognitively intact, re	residents. The Cognition/Behavior/Psychosocial care plan indicated behavioral needs would be assessed, care planned and addressed as deemed appropriate by the interdisciplinary team (IDT). The undated, Group 2 assignment sheet indicated R31 preferred male caregivers. On 9/27/17, R31's quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact, required extensive assist of one staff with bed mobility, transfers, toilet use,					

If continuation sheet Page 15 of 66

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		TE SURVEY		
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG		MPLETED		
						С		
		245267	B. WING			/27/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 225	pain. The assessment no behavioral issue psychoactive medic Registered nurse (F 10/25/17, at 2:23 p. received a voiceman been working on the regarding R31's con devil. RN-H said sh the next day. RN-H incident had ever ha not to take care of F had been satisfied w care of her, so the c documented on a g "did not call it emotif reported to the adm (DON), or the SA. F had received anoth a daughter of anoth was being lifted by who stated NA-G ha and told she needed that she could not constated she had very	and also experienced some ent further indicated R31 had s and was not receiving any cations. RN)-H was interviewed on m. and stated she had il from the nurse who had e evening of 10/22/17, mplaint of being called the he had followed up with R31 stated NA-G had denied the appened, but was instructed R31 again. RN-H said R31 with not having NA-G take	F 2:					
	was transferred to a additional platinum scheduled on 11/1/2 On 10/25/17, a note medical record by that indicated: on 10 nurse that she did r	remarked, at that point NA-G another unit with some service training which was 7. e was documented in R31's he director of nursing (DON) D/22/17, R31 complained to not want the new NA assigned er any longer. R31 stated to						

Facility ID: 00522

If continuation sheet Page 16 of 66

		AND HUMAN SERVICES				FORM	11/27/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245267	B. WING			10/27/2017	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION			000 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	stated "No." The nuresident was satisfied 10/25/17, further in manager followed in concern, notified reassigned to another satisfied. The resides statements of feeline Documentation corresident stated to M of Health) surveyor abused by a NA whadministrator was rand was on-going I to another nursing supervision, so NA resident. On 10/26/17, at 12 interviewed. The E R31 didn't say she stated she didn't like new and I just don't people at all." The expectation of staff was made, staff wor and DON immediation complaint/ grievand thought R31 just di nursing assistant. I didn't think it was a situation. The DON to the resident right feel comfortable if another part of the indicated would be that calling resident.	age 16 she called resident evil and NA urse re-assigned NA and ied. The documentation on dicated on 10/23/17, the nurse up with resident on her esident that NA would be er floor and resident was lent did not make any ng verbal abuse occurred. ntinued on 10/25/17, noted the <i>IDH</i> (Minnesota Department t that she had been verbally no called her evil. The notified, investigation initiated NA has already been assigned unit with extra orientation and will no longer care for the :27 p.m. the DON was DON said "I think at the time was upset about it, but had as that person such as, 'she's t like her.' R31 doesn't like new DON further stated her t was if an allegation of abuse buld inform the administrator tely. She added that since a be form had been used, she'd d not like that particular n addition, the DON said she un emotionally distraught I also stated RN-I had spoken t away and asked if she would they moved that staff to building which R31 had ok. However, the DON verified t's names was verbal abuse, not have to say they were		25			

If continuation sheet Page 17 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245267	B. WING	i			C 27/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION		3	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	The facility failed to verbal/emotional at administrator, DON investigate the alleg R150's quarterly MI R150 had dementia could not complete MDS. The MDS fur extensive assist wit (ADLs) including tra An Occurrence Rep that on 10/3/17, at 7 cares R150 had a to which measured 10 the occurrence rep explain how she su nurse documented, bumped herself into during transfer. Mal indicated." Occurre indicated wound wa R150 sometimes re transfers due to bel indicated in the Cor dated 10/5/17, at 11 bruise incident. The indicated R150 had cares, striking out a attempt to self-trans assistance to transf indicated resident to pattern and bruise I	it to be reported as abuse. report an allegation of buse in a timely manner to the , and State agency and fully gation. DS dated, 8/2/17, indicated a and Alzheimer's disease, and the cognitive portion of the ther noted R150 was an h all activities of daily living ansfers and ambulation. Fort closed 10/6/17, revealed 7:30 a.m. during morning bruise on her right inner thigh 0 centimeter (cm) by 9 cm. Per ort, R150 was unable to stained it. Licensed practical "Res [Resident] must have the Broda chair arm rest treatment and abuse is not nce Report wound description as blackened. Report indicated equired assist of two with naviors. The occurrence report a blackened section of report 1:54 a.m. the IDT reviewed a conclusion section of report a history of being resistive to at staff during cares, would sfer, R150 required staff fer. Occurrence Report oruise was in a non-hand grasp ined up with the armrest of the	F	225			
	happened when R1	uise was likely to have 50 was attempting to sit down vention implemented was					

Facility ID: 00522

If continuation sheet Page 18 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL		(X3) DATE SURVEY	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			PLETED
		245267	B. WING _				C 2 7/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	ONY HEALTH & REH	ABILITATION		-	700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID			ID	,		(-)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	C C	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 225	Continued From pa	ae 18	F 2:	25			
		tinue] to use caution when		20			
	assisting this reside	ent and use Montessori					
		res cooperative with cares."					
		y administrator or director of					
	nursing.						
		notes from 9/3/17, through veal notification of the					
		bruise. Review of progress					
	notes did not indica on arm of Broda ch	te any instance of R150 sitting air.					
		alliative Care Facility Visit					
		cord dated 10/16/17, revealed ious grabbing and upset with					
	cares. R150 was m	ore difficult to redirect with ding bruise on right inner thigh.					
		inted 10/26/17, indicated					
		st of one staff member for 7 until 10/24/17, when care					
	plan was updated.	The intervention dated					
		staff to monitor R150 closely resident attempted to					
	self-transfer and that	at staff would intervene when					
	able to assist reside able.	ent to sit on correct seating as					
	During interview on	10/25/17, at 2:07 p.m. NA-B					
	stated R150 would	become aggressive when					
		ce her fall and was very ng over in bed or stand up and					
	R150 would hit staf	f. NA-B stated R150 had					
		walk. NA-B stated R150 had the arm of the Broda chair					
	when NA-B transfer	rred her.					
	During interview on	10/26/17, at 12:01 p.m. the					

Facility ID: 00522

If continuation sheet Page 19 of 66

		AND HUMAN SERVICES				FORM	: 11/27/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245267		B. WING			C 10/27/2017		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION		-	700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 DON stated whenever there was an incident the nurse would chart the incident and start a risk report. DON stated if the resident cannot say what happened and the staff do not know what happened or there is an allegation of abuse the staff will call the administrator right away, so we could report it. The DON said if something is not reported it would usually be discussed at the IDT meeting the next day and the IDT would come up with a conclusion and put interventions in place. Regarding R150's incident of 10/3/17, DON stated R150 was unable to state what happened but R150 had a history of being resistive and aggressive during cares. DON stated R150 must have bumped her leg during a transfer. When asked when the IDT review the bruise The DON stated 10/5/17. DON said, "We always talk about them the next morning, but [R150] wasn't until 10/5'.DON verified that a bruise in the inner thigh is in a suspicious area. DON stated the Occurrence Report conclusion section was the complete investigation. DON was unable to state when she was informed of the bruise. During interview on 10/26/17, at 1:16 p.m. RN-D stated they did not work on 10/3/17, but "I might have done the investigation the following day but wrote it on 10/5/17." RN-D said, "I honestly can't tell you. If I looked at it Wednesday and investigated it, it would have been 9:30 a.m. after stand up." During interview on 10/26/17, at 2:54 p.m. administrator stated if a bruise of unknown origin was reportable if a resident could not tell you what happened, it was a suspicious area and we could not figure out what happened. The		F	225			

Facility ID: 00522

If continuation sheet Page 20 of 66

		AND HUMAN SERVICES				FORM	11/27/2017 APPROVED 0938-0391
		• •		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245267	B. WING			C 10/27/2017	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	ONY HEALTH & REH	ABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 informed of R150's bruise. The facility Abuse, Neglect and Exploitation policy approved 11/28/16, indicated mandated reporters will immediately report to the: " Administrator/Executive Director " Other Officials in accordance with State Law " State Survey and Certification agency following state protocols. The Policy defines "Abuse" as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse if all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enable through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 4. Mistreatment means inappropriate treatment or exploitation of a resident. 5. Verbal Abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or		F 2	225	DEFICIENCY)		
	regardless of their a disability. 7. Physical Abu hitting, slapping, pir includes controlling punishment.						

If continuation sheet Page 21 of 66

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	1		-	APPROVED . 0938-039 ⁻	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 10/27/2017		
		B. WING _					
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 225 F 226 SS=D	employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility failed to implement their Abuse, Neglect and Exploitation policy when allegations of verbal abuse, or bruises of unknown origin were identified. DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3)		F 22			12/6/17	
	 written policies and (1) Prohibit and pre exploitation of resid resident property, (2) Establish policie 	vent abuse, neglect, and lents and misappropriation of a and procedures to					
	investigate any suc (3) Include training §483.95,	h allegations, and as required at paragraph					
	the freedom from a requirements in § 4	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum					
		constitute abuse, neglect, isappropriation of resident n at § 483.12.					
		or reporting incidents of abuse, n, or the misappropriation of					

If continuation sheet Page 22 of 66

		AND HUMAN SERVICES				FORM	11/27/2017 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		245267	B. WING	B. WING			27/2017	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 226		-	F 2	26				
	resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse prevention policy for 1 of 1 resident (R31) who alleged that staff verbally abused her when they called her evil. In addition, the facility failed to ensure a bruise of unknown origin was reported to the State Agency (SA) in a timely manner for 1 of 1 resident (R150) who had a bruise on the inner thigh. Findings include: The facility Abuse, Neglect and Exploitation policy approved 11/28/16, indicated mandated reporters will immediately report to the: " Administrator/Executive Director " Other Officials in accordance with State Law " State Survey and Certification agency following state protocols. The Policy defines "Abuse" as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse if all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enable through the use of				 F226 Abuse policy 1. The allegation of abuse by R31 h been reported and investigated. The bruise for R150 has been investigat 2. The facility Vulnerable Adult Abuse Prevention policy and procedure has reviewed and remains appropriate. 3. The Administrator and DON atter VAA education at Care Providers jo training on 11/7/17. 4. Staff have been re-educated on the facility Vulnerable Adult Abuse Previous policy and program. 5. The IDT will review each incident determine if reportable and approprior preventative measures are put in plice. 6. The facility QAPI committee will real incidents monthly. 7. See also F225. 8. The Executive Director remains responsible for compliance with this requirement, to ensure that all allegion violations involving mistreatment, no or abuse, including injuries of unknows source are reported immediately 	e ed. se s been nded int he ention to iate ace. review sed eglect,		

If continuation sheet Page 23 of 66

		AND HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES						MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG				
24		245267	B. WING			C 10/27/2017		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	IONY HEALTH & REH			3	700 FOSS ROAD NORTHEAST			
				S	ST ANTHONY, MN 55421			
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE	
ind			inter		DEFICIENCY)			
			1					
F 226	Continued From pa	ge 23	F 2	26				
	-	ndividual must have acted						
		t the individual must have						
	intended to inflict in							
		t means inappropriate						
	treatment or exploit	ation of a resident.						
		language that willfully includes						
	disparaging and	derogatory terms to residents						
		within their hearing distance						
		age, ability to comprehend, or						
	disability.							
		se includes, but not limited to						
	hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal							
	punishment.							
		e failure of the facility, it's						
		ce providers to provide goods						
		sident that are necessary to						
		n, pain, mental anguish, or						
	emotional distress.							
		use, Neglect and Exploitation ons of verbal abuse, or						
		origin were identified.						
	During an interview	with R31 on 10/24/17, at 1:18						
		e had "complained to a nurse						
		nt (NA)-[G] emotionally hurt						
		d her the devil about 20 times."						
		said nobody out here likes the devil." R31 stated she						
		cident to the nurse who was						
	working that night.							
		o the facility on 3/24/17. The						
		esident's record indicated						
		: spinal stenosis of neck,						
		re of first lumbar vertebra, diabetes, and history of						
	stroke.							

Facility ID: 00522

If continuation sheet Page 24 of 66

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES						APPROVED
		& MEDICAID SERVICES						0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X	COM	E SURVEY PLETED
		245267	B. WING				(10/2	; 27/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	ABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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 226	Continued From pa	ge 24	F 2	226				
	R31's care plan dat explain cares and p offer validation of fe chart "prefers male prevention, monitor accusations of abus report all signs and neglect. Staff to ass to prevent bumping residents. The Cog care plan indicated assessed, care plan deemed appropriate (IDT). The undated indicated R31 prefe On 9/27/17, R31's of (MDS) assessment cognitively intact, re staff with bed mobil incontinence cares, pain. The assessment o behavioral issue psychoactive medic Registered nurse (ff 10/25/17, at 2:23 p. received a voicema been working on the regarding R31's con devil. RN-H said st the next day. RN-H incident had ever has not to take care of fi had been satisfied care of her, so the of documented on a g	ed 7/26/17, directed staff to procedures prior to performing, belings, social service note in care givers", abuse for all signs and symptoms, se or neglect. Investigate and symptoms of abuse or sist resident out of dining room into or altercations with other nition/Behavior/Psychosocial behavioral needs would be aned and addressed as e by the interdisciplinary team , Group 2 assignment sheet arred male caregivers. quarterly Minimum Data Set indicated the resident was equired extensive assist of one ity, transfers, toilet use, and also experienced some ent further indicated R31 had s and was not receiving any cations. RN)-H was interviewed on m. and stated she had il from the nurse who had e evening of 10/22/17, mplaint of being called the he had followed up with R31 stated NA-G had denied the appened, but was instructed R31 again. RN-H said R31 with not having NA-G take						

If continuation sheet Page 25 of 66

STATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
		IDENTIFICATION NUMBER:	A. BUILDII	NG	00	MPLETED
		245267	B. WING _)/27/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 226	(DON), or the SA. F had received anoth a daughter of anoth was being lifted by who stated NA-G ha and told she neede that she could not of stated she had very her residents well a unit." RN-H further was transferred to a additional platinum scheduled on 11/1/2 On 10/25/17, a note medical record by t that indicated: on 10 nurse that she did r to her to care for he nurse "I don't like h nurse asked NA if s stated "No." The nu resident was satisfi 10/25/17, further in manager followed u concern, notified re assigned to anothe satisfied. The reside statements of feelin Documentation con resident stated to M of Health) surveyor abused by a NA wh administrator was r and was on-going N	AN-H further stated that she er complaint about NA-G from her family, whose roommate NA-G. The family member ad to be stopped during the lift d help. Then notified RN-H care for her mother. RN-H vexperienced aides who knew and NA-G "can't be on my remarked, at that point NA-G another unit with some service training which was 7. e was documented in R31's he director of nursing (DON) 0/22/17, R31 complained to not want the new NA assigned er any longer. R31 stated to er, she called me evil." The she called resident evil and NA urse re-assigned NA and ed. The documentation on dicated on 10/23/17, the nurse up with resident on her sident that NA would be r floor and resident was ent did not make any ng verbal abuse occurred. tinued on 10/25/17, noted the 1DH (Minnesota Department that she had been verbally o called her evil. The notified, investigation initiated VA has already been assigned unit with extra orientation and	F 2			

If continuation sheet Page 26 of 66

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI				
	F CORRECTION	IDENTIFICATION NUMBER:						
						(C	
		245267	B. WING			10/:	27/2017	
NAME OF F	PROVIDER OR SUPPLIER							
ST ANTH	ONY HEALTH & REH	ABILITATION						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PRÉFIX TAG				X			COMPLETION DATE	
TAG		PEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE From page 26 F 226 7, at 12:27 p.m. the DON was 1. The DON said "I think at the time say she was upset about it, but had didn't like that person such as, 'she's ust don't like her.' R31 doesn't like new ull." The DON further stated her n of staff was if an allegation of abuse staff would inform the administrator mmediately. She added that since a grievance form had been used, she'd i1 just did not like that particular sistant. In addition, the DON said she it was an emotionally distraught F 226						
			1					
F 226	Continued From pa	ge 26	S OMB NO. 0938-0391 A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED B. WING C B. WING C 10 2700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421 D PREFIX TAG PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 226 ne add b e new vuse o a she'd she o, and ne add e. odd add he's a ne owne add he'd she'd aled high					
	On 10/26/17 at 12	27 nm the DON was						
	F 226 Continued From page 26 On 10/26/17, at 12:27 p.m. the DON was interviewed. The DON said "I think at the time R31 didn't say she was upset about it, but had stated she didn't like that person such as, 'she new and I just don't like her.' R31 doesn't like people at all." The DON further stated her expectation of staff was if an allegation of abu was made, staff would inform the administrate and DON immediately. She added that since complaint/ grievance form had been used, sh thought R31 just did not like that particular nursing assistant. In addition, the DON said s didn't think it was an emotionally distraught situation. The DON also stated RN-I had spol-							
						CODE CODE CODE CODE CADACTOR (X5) N SHOULD BE E APPROPRIATE		
							APPROVED 0938-0391 SURVEY PLETED 27/2017	
	expectation of staff	was if an allegation of abuse						
							COMPLETION	
							IPLETED C 27/2017 (X5) COMPLETION	
		away and asked if she would				PLAN OF CORRECTION (X5) CTIVE ACTION SHOULD BE COMPLETION ICED TO THE APPROPRIATE DATE		
	feel comfortable if t	hey moved that staff to					IMPLETED C /27/2017	
		building which R31 had						
		ok. However, the DON verified 's names was verbal abuse,						
		not have to say they were						
		it to be reported as abuse.						
		DS dated, 8/2/17, indicated a and Alzheimer's disease, and					COMPLETION	
		the cognitive portion of the						
		ther noted R150 was an						
		h all activities of daily living						
	(ADLS) including tra	ansfers and ambulation.						
	An Occurrence Rep	port closed 10/6/17, revealed						
	that on 10/3/17, at 7	7:30 a.m. during morning						
		pruise on her right inner thigh						
) centimeter (cm) by 9 cm. Per ort, R150 was unable to						
		stained it. Licensed practical						
	nurse documented,	"Res [Resident] must have						
		the Broda chair arm rest						
		Itreatment and abuse is not nce Report wound description					10/27/2017 (X5) COMPLETION	

Facility ID: 00522

If continuation sheet Page 27 of 66

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/27/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245267	B. WING _				C 27/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	IABILITATION			700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	indicated wound wa R150 sometimes re transfers due to belindicated in the Cor dated 10/5/17, at 1 bruise incident. The indicated R150 had cares, striking out a attempt to self-trans assistance to transfindicated resident b pattern and bruise I Broda chair, and br happened when R1 into the chair. Interv "Staff will cont [con assisting this reside techniques to have The Occurrence Re notification of facilit nursing. Review of progress 10/24/17, did not re administrator of the notes did not indica on arm of Broda ch The Hospice and P Documentation Red R150 was very anx cares. R150 was m cares and had a fac R150's care plan pr R150 required assis transfers from 8/8/1 plan was updated.	as blackened. Report indicated equired assist of two with haviors. The occurrence report nclusion section of report 1:54 a.m. the IDT reviewed e conclusion section of report d a history of being resistive to at staff during cares, would sfer, R150 required staff fer. Occurrence Report oruise was in a non-hand grasp lined up with the armrest of the ruise was likely to have 150 was attempting to sit down vention implemented was tinue] to use caution when ent and use Montessori res cooperative with cares." eport did not indicate ty administrator or director of	F 2	26			

If continuation sheet Page 28 of 66

TATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245267	B. WING		10	C / 27/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 226	self-transfer and tha able to assist reside able. During interview on stated R150 would getting dressed sind nervous about rollin R150 would hit staff declined in ability to never R150 sat on t when NA-B transfer During interview on DON stated wheney nurse would chart th report. DON stated what happened and happened or there is staff will call the adr could report it. The reported it would us meeting the next da with a conclusion an Regarding R150's in stated R150 was ur but R150 had a hist aggressive during of have bumped her le asked when the IDT stated 10/5/17. DOI them the next morn 10/5".DON verified 10/5/17. DON verified 10/5/17. DON verified 10/5/17. DON verified	resident attempted to at staff would intervene when ent to sit on correct seating as 10/25/17, at 2:07 p.m. NA-B become aggressive when ce her fall and was very ig over in bed or stand up and f. NA-B stated R150 had walk. NA-B stated R150 had the arm of the Broda chair	F 2			

If continuation sheet Page 29 of 66

		AND HUMAN SERVICES	_		F	ORM	11/27/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3	COM	E SURVEY PLETED
		245267	B. WING			(10/2	27/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION			700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 226	Continued From pa	ige 29	F 2	226			
F 241 SS=D	stated they did not the have done the investive wrote it on 10/5/17. tell you. If I looked a investigated it, it works investigated it, it works and up." During interview on administrator stated was reportable if a what happened, it works are portable if a what happened, it works administrator was upon administrator administrator was upon administrator administrator administrator was upon administrator administrator was upon administrator administratore	BPECT OF INDIVIDUALITY 1) Set treat and care for each er and in an environment that unce or enhancement of his or cognizing each resident's cility must protect and	F2	241	F241 Dignity and Respect of Individuality 1. The identified resident R150 has has her care plans and NAR assignment sheets reviewed and updated as need to include providing for privacy and dignity. 2. The responsible staff were re-educa on privacy and dignity as soon as notifi of the concern during the annual surve	ad ded ated fied	12/6/17

Facility ID: 00522

If continuation sheet Page 30 of 66

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
				·	(C
		245267	B. WING		10/2	27/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 241 F 246 SS=D	resident's name], I most." Registered r present added, "Th "I would swear thes and take water pills these statements in R150's quarterly Mi 8/2/17, indicated R Alzheimer's disease cognitive portion of noted R150 was an and R150 was freq and bowel. During interview on verified making the and stated she was During interview on stated she thought information to expla changed every two should have waited done providing R15 REASONABLE ACO NEEDS/PREFERE CFR(s): 483.10(e)(483.10(e) Respect a right to be treated including: (e)(3) The right to r the facility with reas	Between her and [another don't know who wets the nurse (RN)-C who was also ey wet a lot." NA-B remarked, se two drank 50 gallons a day " NA-B and RN-C made n front of R150. inimum Data Set (MDS) dated, 150 had dementia and e, and could not complete the the MDS. The MDS further n extensive assist with all ADLs uently incontinent of bladder 10/25/17, at 2:07 p.m. NA-B statements in front of R150 a nervous. 10/25/17, at 2:22 p.m. RN-C NA-B was trying to provide ain that all residents were hours. RN-C confirmed NA-B to explain that until they were 50's care. COMMODATION OF NCES	F 241	 Staff will be re-trained on prov resident privacy and dignity using examples cited in the CMS-2567 Nursing leadership will assess and dignity competency on 6 stat members a week until all nursing have been assessed. Nursing leadership will also lo potential privacy and dignity issu completing various scheduled at as med pass audits, NAR direct audits, toileting, etc. The Director of Nursing will re completed audits and bring any privacy concerns to the facility Q committee for review and further recommendations. The Director of Nursing remai responsible for compliance with requirement to ensure residents to personal privacy and confident 8. See also F164 	y specific privacy ff y staff ok at es while udits such care view the dentified API ns this the right	12/6/17

If continuation sheet Page 31 of 66

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DAT CON	. 0938-039 E SURVEY IPLETED
		245267	B. WING _			C 2 7/2017
	PROVIDER OR SUPPLIER	IABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 246	resident or other re This REQUIREMEN by: Based on observareview, the facility f easily accessible in assistance for 1of 6 have a call light not Findings include: R26's care plan eff indicated R26 had staff to keep the car R26's annual Minin 9/22/17, indicated R impairment and rea from two staff mem (ADLs) that involve identified R26 for b On 10/23/17, at 4:1 their room, seated the end of the bed button placed under unable to reach the did use the call light licensed practical n light was not within reposition the call light the reach. During an interview whoever walked in	sidents. NT is not met as evidenced tion, interview, and document ailed to ensure a call light was order to summon staff 6 residents (R26) observed to	F 24	 F246 Accommodation of Needs 1. Resident R28 care plans and I assignment sheets have been re and updated as needed. 2. Staff will be re-trained on provi resident accommodation of need specific survey examples cited in 2567. 3. Facility leadership will complet light placement audits 2x/week u next QAPI meeting 12/19/17. 4. The Director of Nursing will rev completed audits and bring any id concerns to the facility QAPI com for review and further recommen 5. The Executive Director remain responsible for compliance with t requirement to ensure residents a provided services with reasonabl accommodation of individual nee 	viewed ding for s, using the e call ntil the view the dentified mittee dations. s his are e	

If continuation sheet Page 32 of 66

		AND HUMAN SERVICES			FORM	D: 11/27/2017 MAPPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245267	B. WING		10	C / 27/2017
NAME OF F	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	
ST ANTH	IONY HEALTH & REH	ABILITATION			700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	resident had a call l included: "Call light reach of the resider	he facility to determine the light with reach. The policy s must always be placed in the nt."		246		
F 250 SS=D	SERVICE CFR(s): 483.40(d) (d) The facility mus	EDICALLY RELATED SOCIAL t provide medically-related ttain or maintain the highest	F	250		12/6/17
	practicable physica well-being of each r This REQUIREMEN by: Based on observat review, the facility fa assessment and se (R186) diagnosed w	l, mental and psychosocial			F250 Provision of Medical Related Social Service 1. R186 was immediately offered psychology services, and refused. SS to continue to offer psychology services to	
	certified nurse prac weighed 68.5 pound index) of 11.8. R186's admission of 5/28/15, included di	note dated 5/19/15, by the titioner (CNP), indicated R186 ds and had a BMI (body mass diagnoses report dated iagnoses of bipolar disorder causes shifts in ability to think			 resident at each care conference and PRN. 2. All residents in the building were reviewed for appropriate of psychology services, and assessed by psychology as desired by resident. 3. The facility has developed a psycholog referral procedure. 4. Social Service staff educated on the psychology referral procedure. 	
	clearly) and anorex characterized by se R186's care plan, e indicated R186 had related to poor appo	ia (an eating disorder			 5. All staff has been assigned the course mental health needs of the older adult in HCA for the month of December. 6. All residents will continue to be reviewed for appropriate psychology services during every care conference. 7. The facility QAPI committee will review 	,

Facility ID: 00522

If continuation sheet Page 33 of 66

		AND HUMAN SERVICES				FORM	: 11/27/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245267	B. WING				C 27/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION		-	700 FOSS ROAD NORTHEAST IT ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 250	dated 1/9/17, indica and social services as needed. R186's ADL verifica through 10/25/17, in a small percentage The Care Conferent indicated R186 refu- had a poor intake a On 10/26/17, R186 69.0 pounds. R186 followed up on per On 10/25/17, at 9:1 physician was inter remember writing a consultation and he care of that. During an interview registered nurse (F usually wrote an or and R186 did not h consultation. A clinical note dated process, at 12:08 p worker met with R1 psychology service	e from the facility social worker ated R186 had a poor appetite would monitor and follow up ation worksheets dated 8/31/17 ndicated R186 consumed ate of one to two meals per day. the note dated 10/5/17, used dietary supplements and it meal time. 's weight was documented as weight loss needs were not the social note of 1/9/17. 0 a.m., R186's treating viewed and said he did not an order for a psychiatric thought social services took on 10/25/17, at 10:32 a.m. N)-F said the physician der for a psychiatric consult ave an order for a d 10/25/17, during the survey i.m. indicated the facility social 86 and offered in-house	F 2	250	DEFICIENCY) residents receiving psychology servand make further recommendation 8. The Executive Director remains responsible for compliance with thi requirement, to ensure that resider receive social services to attain or maintain the highest practicable ph mental and psychosocial well-being each resident.	s. s its ysical,	
	director of nursing	said she expected psychiatric be offered to residents with					

If continuation sheet Page 34 of 66

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		C
		245267	B. WING _			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 250	have requested psy During an interview the facility dietician assessment of R18 the facility. The diet benefitted from a ps understand why R1 dietician could not f	ge 34 es and social services should rchiatric consultation. on 10/26/17, at 11:38 a.m., said she had not done an 6 nutrition, as she was new to ician stated R186 would have sychiatric consult to better 86 was not eating. The current ind evidence in the medical al assessment being	F 25	50		
F 282 SS=D	dated 1/30/13, indic notified by nursing s intervention and nu order and notify soc services will contac provider for service SERVICES BY QU/ CARE PLAN CFR(s): 483.21(b)(3) (b)(3) Comprehensi The services provid	ALIFIED PERSONS/PER 3)(ii)	F 28	32		12/6/17
	care. This REQUIREMEN by: Based on observat review, the facility fa	qualified persons in ch resident's written plan of NT is not met as evidenced ion, interview and document ailed to follow the plan of care (R29) reviewed for urinary		F282 Services Provided per Care Plan 1. Resident R29 s care plans and	INAR	

Facility ID: 00522

If continuation sheet Page 35 of 66

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	0938-039 SURVEY PLETED
		245267	B. WING		(10/2	; 27/2017
	PROVIDER OR SUPPLIER	IABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 282	AG REGULATORY OR LSC IDENTIFYING INFORMATION)			 sheets reviewed and revised as mareflect current bladder incontinent status. 2. Other residents will have their T care plans updated with each quated annual, or significant change of composed of MDS. 3. Staff will be in-serviced on follor care plan interventions/NAR assignsheets and toileting schedules using specific survey findings as an exated. Nursing leadership will completed toileting competencies on 8 staff puntil all NAR staff have been composed to to the facility QAPI committee will completed toileting competency reand make further recommendation 6. See also F312 7. The Director of Nursing remainar responsible for compliance with the requirement, to ensure that servic provided in accordance with each resident s plan of care. 	e foileting rterly, ondition wing nment ng mple. e wer week bleted. I review esults ns. s is	
	with pad change ar every shift. Garden Court NA (I Sheet, not dated, in of bowel and bladd	ed) AX1 (assist times 1). AX1 nd pericare after incontinence Nursing Assistant) Report ndicated R29 was incontinent er, was to offer toileting upon meals, HS, NOC rounds and				

If continuation sheet Page 36 of 66

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		VG) CO	MPLETED		
		245267	B. WING _		10	C / 27/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	CODE			
ST ANTH	IONY HEALTH & REH	ABILITATION	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 282	During continuous of 7:18 a.m. to 10:29 a -At 7:18 a.m., R29 dining room via who -From 8:08 a.m. to eating breakfast wit Garden Court day r -At 9:02 a.m., NA-A gait belt around the from wheelchair to -From 9:24 a.m. to eyes closed in the of -From 9:24 a.m. to and observed watc with staff. -From 10:29 a.m. to and observed watc with staff. -From 10:29 a.m. to sit in day room cha During an interview when asked NA-B i incontinence care w the bathroom when further stated R29 r and does not void r when she took her she had not taken F to toileting R29. NA "felt to see if she w her to the other cha You can usually tell During an interview when asked to desi for incontinence NA bottom to make sur	observation on 10/25/17, at a.m., for incontinence care: was brought into Garden Court eel chair. 8:58 a.m., R29 was observed th staff assist, then brought to room by staff. was observed to place the R29's waist, transferred R29 day room chair. 9:47 a.m., R29 observed with day room. 10:12 a.m., R29 was awake hing television and interacting o 10:41 a.m., R29 continued to		32				

If continuation sheet Page 37 of 66

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION (X3) [DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			OMPLETED
					С
		245267	B. WING _		0/27/2017
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 282	Continued From pa	ge 37	F 28	2	
	stated staff should expected a pad che RN-D further stated center of the pad w tell, can see visually reference to how to incontinence pad. F to do a visual pad c During an interview (DON) when asked check R29's incont	re, registered nurse (RN)-D follow the care plan and eck, prefer to check in private. If there are markings on the hich changes color, "you can y on the outside of the pad" in check saturation on the RN-D stated she would prefer sheck in a private area.			
	requested, policy tit Plans" was given.	llowing the care plan was led "Comprehensive Care DED FOR DEPENDENT 2)	F 31	2	12/6/17
	activities of daily liv services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility f (R29) reviewed who	NT is not met as evidenced tion, interview and document ailed to ensure 1 of 5 residents o was dependent on staff eting, received care and		F312 ADLs 1. Resident R29 s care plans and NAR sheets reviewed and revised as needed reflect current bladder incontinence status. 2. Other residents will have their Toiletin	to

Event ID:0QGF11

Facility ID: 00522

If continuation sheet Page 38 of 66

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED	
		245267	B. WING			C 27/2017	
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE			
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAS ST ANTHONY, MN 55421	т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIC DATE	
F 312	R29's face sheet da diagnoses including disturbance and ost Minimum Data Set indicated the reside words regarding spe impaired cognition. of one person to tra wheelchair, and req person for toilet use elimination and pad assessment (CAA) 9/1/17, indicated the understood verbally CAA for urinary inco catheter indicated F required extensive a and was not able to change her pads, o R29's care plan, eff present, indicated ru and bladder function incontinence of bow staff to offer toileting meals, HS (at bedtin and PRN (as neede with pad change an every shift. The Garden Court N Sheet, not dated, in of bowel and bladder rising, before/after r PRN AX1.	ge 38 ated 10/2013, indicated i: dementia without behavioral aeoarthritis. R29's annual (MDS) dated 8/23/17, nt had an absence of spoken eech clarity and had severely R29 required extensive assist nsfer to or from bed, chair, or uired extensive assist of one e including cleansing self after changes. R29's care area for communication, dated e resident was never/rarely c, did not speak and was deaf. ontinence and indwelling R29 was frequently incontinent, assist of one staff for toileting manage incontinence, r take care of own pericares. ective date 10/30/17, to esident's alteration in bowel n due to dementia, frequent vel and bladder directed facility g upon rising, before/after me), NOC (at night) rounds ad) AX1 (assist times 1). AX1 d pericare after incontinent er, was to offer toileting upon neals, HS, NOC rounds and bbservation on 10/25/17, at	F 31	2 care plans updated witi annual, or significant cl MDS. 3. Staff will be in-service care plan interventions sheets and toileting scl specific survey findings 4. Nursing leadership v toileting competencies until all NAR staff have 5. The facility QAPI con completed toileting con and make further recor 6. See also F282 7. The Director of Nurs responsible for complia requirement, to ensure receive the appropriate services to improve/ma	hange of condition eed on following /NAR assignment hedules using as an example. vill complete on 8 staff per week been completed. mmittee will review npetency results mmendations. ing remains ance with this that residents e treatment and		

		AND HUMAN SERVICES					FORM	: 11/27/2017 APPROVED . 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		COM	E SURVEY IPLETED
		245267	B. WING	à				C 27/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, Z	IP CODE		
ST ANTH	IONY HEALTH & REH	IABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD	BE	(X5) COMPLETION DATE
F 312	dining room via whe -From 8:08 a.m. to eating breakfast wit Garden Court day r -At 9:02 a.m., nursi observed to place t waist, transferred F room chair. -From 9:24 a.m. to eyes closed in the o -From 9:49 a.m. to and observed watc with staff. -From 10:29 a.m. to sit in day room cha During an interview when asked NA-B i incontinence care w the bathroom when further stated that F hours and does not dry when she took verified she had no reference to toiletin that NA-A "felt to se transferred her to th her down. You can During an interview when asked to dese for incontinence NA bottom to make sur resident was transf day room. During an interview when asked what here	eel chair. 8:58 a.m., R29 was observed th staff assist, then brought to room by staff. ng assistant (NA)-A was the gait belt around the R29's R29 from wheelchair to day 9:47 a.m., R29 observed with day room. 10:12 a.m., R29 was awake hing television and interacting to 10:41 a.m., R29 continued to		31:	2			

If continuation sheet Page 40 of 66

					<u>1B NO. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		245267	B. WING _		10/27/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST	
ST ANTH	IONY HEALTH & REH	ABILITATION		ST ANTHONY, MN 55421	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 312 F 333 SS=E	stated staff should further stated there the pad which chan see visually on the reference to how to incontinence pad. Facility policy titled 12/6/12, indicated t Care and Comfort of resident clean, dry hours and/or at pre maintain the reside prevent skin break The policy further in be checked, toileted hours. It may be mo is present." RESIDENTS FREE ERRORS CFR(s): 483.45(f)(2 483.45(f) Medicatio The facility must en (f)(2) Residents are medication errors. This REQUIREMEN by: Based on observat review, the facility fi free of significant m residents (R221, R	follow the care plan. RN-D are markings on the center of ages color, "you can tell, can outside of the pad" in o check saturation on the "Incontinence Care" dated hat "Scheduled Incontinent consists of keeping the and comfortable every two determined intervals, to nt in a clean and dry state to down such as excoriations." indicated that "The resident will d and/or changed every two ore frequent if skin breakdown E OF SIGNIFICANT MED 2) in Errors.	F 31	2	

Facility ID: 00522

If continuation sheet Page 41 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES	1			PRINTED: 11/27/201 FORM APPROVE OMB NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY PLETED	
		245267	B. WING	i		C 10/27/2017		
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	ONY HEALTH & REH	ABILITATION		_	0700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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 333	Continued From pa sugars).	ge 41	F	333	Medication Error Report completed	, MD		
	sugars). Findings include:				notified, and insulin orders reviewed Identified staff involved in these medication errors were re-educated	d.		
	9/14/17, indicated F received insulin injet had a diagnosis of o where blood sugars	nimum Data Set (MDS) dated R221 was cognitively intact, ections seven days a week and diabetes mellitus (a disease s are too high) with rve damage related to			 the error as part of the medication ereport. 3. All other residents with an order in Insulin have had their insulin check expiration dates. 4. Licensed Nurses will be in-service medication administration and store 	error for ed for ed on age		
	10/23/17, at 7:12 p. (LPN)-C prepared F vial of Lantus was of to LPN-C entering F LPN-C and had him the vial. LPN-C veri and he had not bee stated Lantus is onl	administration observation on m. licensed practical nurse R221's Lantus 22 units. The dated as opened 9/18/17. Prior R221's room surveyor stopped in check the expiration date on fied the Lantus was expired in aware it was expired. LPN-C by good for 28 days after it eration, and should have been /17.			 Licensed Nurses have been assi education on medication administra and Diabetes through Health Care Academy to be completed by 12/6/ PharMerica Nurse Consultant wil conduct a medication administration storage audit on 11/28/17 and 11/29 All Nurses will complete a medic storage self competency each shift work until the next QAPI meeting 12/19/17. Nursing leadership will complete Medication administration compete 	ation 17. Il n and 9/17. ation they		
	Records (MAR) rev dated 10/2/17, for L received Lantus 22 10/23/17. R221's bl milligrams/deciliter(range 70-100 mg/d from 10/2/17, to 10/ varied from 101mg/ of time from 10/16 t R15's quarterly MD was moderately ind making, received in	17 Medication Administration ealed R221 had an order antus 22 units daily. R221 units from 10/2/17 through ood sugars varied from 83 mg/dl) -217 mg/dl (normal l) during the period of time /15/17. R221's blood sugars /dl-207mg/dl during the period through 10/23/17. S dated 9/9/17, indicated R15 ependent with decision isulin injections seven days a ignosis of diabetes mellitus.			assessments on 5 Nurses per weel all Nurses have been assessed. 9. Nursing leadership will complete medication storage competency au weekly until the next QAPI meeting 12/19/17. 10. The facility QAPI committee will review completed audits and medic error reports monthly and make fur recommendations. 11. See also F431. 12. The Director of Nursing remains responsible to ensure residents are any significant medication errors.	ation competency urses per week until assessed. o will complete 5 ompetency audits QAPI meeting committee will dits and medication and make further ursing remains e residents are free of		

Facility ID: 00522

If continuation sheet Page 42 of 66

		AND HUMAN SERVICES					FORM	APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	-E CONSTRUCTION	0		0938-0391 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:						PLETED
			-					2
		245267	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODI		10/2	27/2017
	PROVIDER OR SUPPLIER				700 FOSS ROAD NORTHEAST	:		
ST ANTH	IONY HEALTH & REH	ABILITATION			ST ANTHONY, MN 55421			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE			(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP			COMPLETION DATE
					DEFICIENCY)			
E 222		40						
F 333	Continued From pa	ge 42	F 3	333				
	During medication of	cart observation on 10/23/17,						
	at 7:21 p.m. Lantus	vial for R15 was observed						
		9/22/17. LPN-D verified the as opened 9/22/17, and						
		only good for 28 days. R15						
	stated R15 had rec	eived Lantus that day.						
	I wenty-eight days f	rom 9/22/17, was 10/19/17.						
	R15's October 2017	7 MAR revealed R15 had an						
		7, for Lantus 12 units daily.						
		IS 20 units from 10/1/17, R15 received Lantus from an						
	expired vial for four	days. R15's blood sugars						
		/dl-278 mg/dl during the period						
	of time from 10/19/	Inrough 10/23/17.						
		S dated 10/5/17, indicated						
		ys a week and had a						
	diagnosis of diabete							
	During medication	cart observation on 10/23/17,						
		vial for R127 was observed						
		hat indicated date open of						
		tion date of 10/15/17. RN)-G stated R127 was						
		pital and had been admitted to						
	the hospital on 10/2	28/17. RN-G verified date on						
		d it had been opened 9/17/17, was only good for 28 days.						
		ato only good for 20 days.						
		17 MAR revealed R127 had an						
		7, for Lantus 20 units daily. Lantus 20 units from						
		27 received Lantus from an						
	expired vial for four	days after it expired.						

If continuation sheet Page 43 of 66

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION			SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG				PLETED
		245267	B. WING			C 10/27		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CC 3700 FOSS ROAD NORTHEAST					
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 F ST Al				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	κ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD I	ЗE	(X5) COMPLETIC DATE
F 333	indicated R127's La and should have be R57's quarterly MD R57 was severely of insulin injections se diagnosis of diabet During medication at 9:46 a.m. Lantus with a sticker on it i 9/21/17, LPN-E ver morning. LPN-E sta and for some reaso the Lantus vial was should have been of LPN-E verified R57 medication cart dat should have been of day on 10/18/17. L received NovoLog expired medication medication error. During interview or stated giving expire medication error. R57's October 201 order dated 8/3/17, had received Lantu	Preport closed 10/25/17, antus vial was opened 9/17/17, een discarded 10/15/17. OS dated 9/20/17, indicated cognitively impaired received even days a week and had a	F 3	33				

Facility ID: 00522

If continuation sheet Page 44 of 66

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION		E SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	ING	i		PLETED	
		245267	B. WING				C 27/2017	
NAME OF PROVIDER OR SU	PPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTHONY HEALTH	& REH	IABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
PREFIX (EACH DEF	ICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
 During interv Medical Direction would be a m During interv director of nu- expected the any vial of ins- not give the e Lantus and N from the time or when they giving expirec- error. Food and Dru- insert NDA 2th "NovoLog in NovoLog Fle stored betwe freeze. Do no or exposed to (98.6 °F). After syringe has b temperatures days, but sho heat or sunlig Sanofi-aventi 8/2015, indic days at room or unopened Medication A policy dated s insulin. Chec 	Novold iew on ctor giv nedica iew on irses (nurses (nurses lovoLo e they v were d insul ug Adr 0-986/ unope xPen I en 2° o temper a via been p s below buld no ght." is Lant ated L temper d insul befor bot se below buld no ght."	og insulin after 10/18/17. 10/24/17, at 1:04 p.m. facility ving a resident expired insulin	F 3	:33				

Facility ID: 00522

If continuation sheet Page 45 of 66

		AND HUMAN SERVICES				FORM	: 11/27/2017 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	CON	E SURVEY IPLETED
		245267	B. WING	i			C 27/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	ONY HEALTH & REH	IABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333		-	F	333			
F 356 SS=C		STAFFING INFORMATION	F	356			12/6/17
		nformation ents. The facility must post nation on a daily basis:					
	(i) Facility name.						
	(ii) The current date	9.					
	by the following cat	er and the actual hours worked regories of licensed and staff directly responsible for hift:					
	(A) Registered nurs	ses.					
		cal nurses or licensed as defined under State law)					
	(C) Certified nurse	aides.					
	(iv) Resident censu	IS.					
	(2) Posting requirer	ments.					
	specified in paragra	post the nurse staffing data aph (g)(1) of this section on a eginning of each shift.					
	(ii) Data must be po	osted as follows:					
	(A) Clear and reada	able format.					
	(B) In a prominent	place readily accessible to					

If continuation sheet Page 46 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	NO. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED	
		245267	B. WING			(10/2	C 27/2017	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				3	700 FOSS ROAD NORTHEAST			
SIANIH	THONY HEALTH & REHABILITATION			S	ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 356	Continued From paresidents and visito (3) Public access to The facility must, up make nurse staffing for review at a cost standard. (4) Facility data reter facility must maintains staffing data for a maintain staffing data for a maintains staffing data for a maintains the potential to affect visitors. Findings include: A review of actual s postings revealed: On 5/4/17, one add on the day shift that On 6/27/17, the staff and did not match the Staff posting incorrect nurses (RNs) when practical nurse (LPP counted as RN not transcription error of	ge 46 rs. posted nurse staffing data. oon oral or written request, g data available to the public not to exceed the community ention requirements. The in the posted daily nurse hinimum of 18 months, or as w, whichever is greater. NT is not met as evidenced ntation and interview, the ate their staff posting when in the actual staffing. This had ct all residents, families and taffing sheets and actual staff itional nursing assistant (NA) in on the staff posting. If posting was not updated he actual staffing schedule. ectly counted three registered two worked and onelicensed N) filled RN spot and was	1	356	DEFICIENCY)	affing ains pors w and k/week ting w the ntified ittee tions.		
	trained medication a and was replaced b	aide (TMA), an aide called in y a NA. The staff posting was not match the actual staffing			requirement that Nurse Staffing is p			

Facility ID: 00522

If continuation sheet Page 47 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	: 11/27/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	0	(X3) DAT COM	E SURVEY IPLETED
		245267	B. WING	i				C 27/2017
NAME OF	PROVIDER OR SUPPLIER		<u>.</u>		STREET ADDRESS, CITY, STATE, ZIP C	ODE	•	
ST ANTH	IONY HEALTH & REH	ABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 356	Continued From pa	ge 47	F	356	3			
		vas lacking, one NA over the ident on subacute fell and e.						
	one LPN called in c one NA called in for called in for the day	s called in for the night shift, on the day shift. One RN and the evening shift. One NA shift. The DON worked the cility charge nurse on the night						
	did not match the a posting listed two R additional LPN on s staff posting. The n	posting was not updated and ctual staffing schedule, Staff N's, three RN's worked. One schedule that was not on the ight shift listed two RN and ual worked schedule was one s.						
	on evening shift cal not updated and did schedule, one NA o part of staff, althoug	N day shift calling and two NA led in. The staff posting was d not match the actual staffing on orientation was counted as gh the DON and staffing hey were not counted in staff.						
	and did not match t any shift. One RN v actual schedule. NA	ff posting was not updated he actual staffing schedule on vas replaced by an LPN on the A's higher than posted was replaced by two LPN on						
	and did not match t any shift, two LPN's posting, but were n	ff posting was not updated he actual staffing schedule on were counted on the day staff ot found on the actual clacking on evening shift. One hight shift.						

If continuation sheet Page 48 of 66

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI			IB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED		
		245267	B. WING				C 27/2017	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	ABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE	
F 356	Continued From pa	ge 48	F 3	856				
	not provided, two st	ff posting was requested by taff were pulled to TMA (there bry on the staff posting), two orientation.						
	for the day shift. Th updated and did no	RN, one LPN, one NA called in e staff posting was not t match the actual staffing tion error occurred on the day						
F 431 SS=E	(DON) and staffing The staffing pattern determined by cens DON for each unit a aware that the curre the quality of care a identified during the complaints. Stated when staffing conce nurse managers he breakfast and lunch had brought concer replied "it comes up groups when bring sometimes yah, I m not elaborate furthe	sus and then by direction of the according to census. DON was ent staffing may contribute to and quality of life concerns e survey and by substantiated "I know it takes a little longer erns, if call in nurses then op more, all go help with n meals." When asked if staff rns about workloads the DON operiodically, depends on the to managers to redo groups, nean it depends." The DON did er. LABEL/STORE DRUGS &	F 4	131			12/6/17	
	The facility must produces and biologica them under an agres §483.70(g) of this p	ovide routine and emergency als to its residents, or obtain ement described in art. The facility may permit all to administer drugs if State						

Facility ID: 00522

If continuation sheet Page 49 of 66

		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	0MB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			a		PLETED
							С
		245267	B. WING			10/:	27/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST		
ST ANTH	IONY HEALTH & REH	ABILITATION			ST ANTHONY, MN 55421		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIC		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
E 404							
F 431	Continued From pa	-	F 4	31			
	supervision of a lice	y under the general ensed nurse.					
		acility must provide vices (including procedures					
		urate acquiring, receiving,					
		ministering of all drugs and the needs of each resident.					
	biologicals) to meet						
		ation. The facility must e services of a licensed					
	disposition of all co	vstem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and					
	that an account of a	drug records are in order and all controlled drugs is iodically reconciled.					
	labeled in accordan professional princip appropriate access	als used in the facility must be ice with currently accepted iles, and include the					
	the facility must sto locked compartmer	vith State and Federal laws, re all drugs and biologicals in hts under proper temperature t only authorized personnel to					
		t provide separately locked, I compartments for storage of					

If continuation sheet Page 50 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVE . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245267	B. WING			C 27/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ST ANTH	IONY HEALTH & REH	ABILITATION				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 431	Comprehensive Dru Control Act of 1976 abuse, except wher package drug distril quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, the facility fa residents (R221, R1 Lantus (a long actim treatment of elevate receive expired men (R57) who received insulin for the treatment did not receive expi Findings include: R221's five-day Min 9/14/17, indicated F received insulin injet had a diagnosis of of where blood sugars polyneuropathy (net diabetes). During medication a 10/23/17, at 7:12 p. (LPN)-C prepared F of Lantus was dated LPN-C and had him the vial. LPN-C veri and he had not bee stated Lantus is onl	ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced ion, interview and document ailed to ensure 4 of 20 I5, R127, R57) who received ig insulin used for the ed blood sugars) did not dication and 1 of 8 residents NovoLog (a short acting nent of elevated blood sugars) red medication.	F 4	 The identified expired insremoved from the med cart notified about the concern of annual survey. R221, R15, R127, and R Medication Error Report connotified, and insulin orders related to a part of the medication errors were react the error as part of the medication errors were react the error as part of the medication dates. Licensed Nurses will be i medication administration at Licensed Nurses have be education on medication administration at S. Licensed Nurses have be education on medication administration at Academy to be completed to 6. PharMerica Nurse Consucconduct a medication administorage audit on 11/28/17 a 7. All Nurses will complete a storage self competency ea work until the next QAPI met 12/19/17. Nursing leadership will complete a storage self competency ea work until the next gap in the set of the next gap in the next gap in the set of the next gap in the next gap in the set of the next gap in the set of the next gap in the next gap in the set of the next gap in the next gap in the set of the next gap in the next gap in the next gap in the set of the next gap in the next gap in the set of the next gap in the next gap in the next gap in the set of the next gap in the n	s as soon as during the 57 have had a mpleted, MD reviewed. hese educated on lication error n order for n checked for n-serviced on and storage een assigned liministration th Care by 12/6/17. ultant will nistration and nd 11/29/17. a medication the shift they betting complete omplete omplete	

Facility ID: 00522

TATEMEN	OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT CON	. 0938-039 E SURVEY IPLETED	
		245267	B. WING _			C / 27/2017	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	IABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 431	destroyed on 10/15 R221's October 20 Records revealed F 10/2/17, for Lantus Lantus 22 units from R221's blood sugar milligrams/deciliterr range 70-100 mg/d from 10/2/17, to 10 varied from 101mg of time from 10/16 R15's quarterly MD was moderately ind making, received in week and had a dia During medication at 7:21 p.m. Lantus with a date open of vial had been dated stated Lantus was stated R15 had rec Twenty-eight days R15's October 201 Records revealed F 9/26/17, for Lantus Lantus 20 units from R15 received Lantu days. R15's blood s 124mg/dl-278 mg/d from 10/19/ through	 5/17. 17 Medication Administration R221 had an order dated 22 units daily. R221 received m 10/2/17 through 10/23/17. rs varied from 83 (mg/dl) -217 mg/dl (normal II) during the period of time /15/17. R221's blood sugars /dl-207mg/dl during the period through 10/23/17. 28 dated 9/9/17, indicated R15 dependent with decision nsulin injections seven days a agnosis of diabetes mellitus. cart observation on 10/23/17, s vial for R15 was observed 9/22/17. LPN-D verified the d as opened 9/22/17, and only good for 28 days. R15 evived Lantus that day. from 9/22/17, was 10/19/17. 7 Medication Administration R15 had an order dated 12 units daily. R15 received m 10/1/17, through 10/23/17. us from an expired vial for four sugars varied from dl during the period of time 	F 43	all Nurses have been assessed. 9. Nursing leadership will compl medication storage competency weekly until the next QAPI meet 12/19/17. 10. The facility QAPI committee review completed audits and me error reports monthly and make recommendations. 11. See also F333. 12. The Director of Nursing rem responsible for compliance with requirement to ensure that pharmaceutical services are pro meet the needs of each residen	ete 5 audits ing will edication further ains this vided to		

If continuation sheet Page 52 of 66

	OF DEFICIENCIES OF CORRECTION	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION	(X3) D	D. 0938-039 ATE SURVEY DMPLETED	
		245267	B. WING		1	C 0/27/2017	
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP			
ST ANTH	IONY HEALTH & REI	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE	(X5) COMPLETIC DATE	
F 431	Continued From pa	age 52	F 4	31			
	injections seven da diagnosis of diabet	ays a week and had a les mellitus.					
	at 7:24 p.m. Lantus with a sticker on it 9/17/17, and expira Registered nurse (currently in the hos the hospital on 10/ Lantus vial indicate	cart observation on 10/23/17, s vial for R127 was observed that indicated date open of ation date of 10/15/17. RN)-G stated R127 was spital and had been admitted to 28/17. RN-G verified date on ed it had been opened 9/17/17, was only good for 28 days.					
	R127's October 20 Records revealed 10/9/17, for Lantus received Lantus 20	17 Medication Administration R127 had an order dated 20 units daily. R127 had 0 units from 10/11-10/19/17. Itus from an expired vial for					
	indicated R127's L	report closed 10/25/17, antus vial was opened 9/17/17, een discarded 10/15/17.					
	R57 was severely	DS dated 9/20/17, indicated cognitively impaired received even days a week and had a tes mellitus.					
	at 9:46 a.m. Lantus with a sticker on it 9/21/17, LPN-E ve morning. LPN-E st and for some reas the Lantus vial was should have been	cart observation on 10/24/17, s vial for R57 was observed that indicated date open of rified R57 received Lantus that ated she had given the Lantus on had not checked the date s opened. LPN-E stated the vial disposed of on 10/18/17. 7 had a vial of NovoLog in the					

If continuation sheet Page 53 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245267	B. WING				C 27/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION			700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	should have been of day on 10/18/17. Lf received NovoLog t expired medication medication error. During interview on stated giving expire medication error. R57's October 2017 Records revealed F for Lantus 20 units Lantus 20 units fror R57 received Lantu days after it expired Administration Reco order dated 9/18/17 times a day based of 249 mg/dl. R57 had Novolog insulin after During interview on Medical Director giv would be a medicat During interview on director of nurses (I expected the nurse any vial of insulin at not give the expired Lantus and NovoLo from the time they v or when they were of giving expired insul error.	ed opened 9/21/17 which lisposed of at the end of the PN-E stated R57 had not hat day. LPN-E stated an that was given would be a 10/24/17, at 10:01 a.m. RN-D d insulin would be a 7 Medication Administration R57 had an order dated 8/3/17, daily. R57 had received n 10/1/17, through 10/24/17. Is from an expired vial for six I. R57's October Medication ords revealed R57 had an 7, for Novolog insulin three on blood sugars greater than I received six doses of er 10/18/17. 10/24/17, at 1:04 p.m. facility <i>r</i> ing a resident expired insulin	F	431			

If continuation sheet Page 54 of 66

		AND HUMAN SERVICES				FORM	: 11/27/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED C
		245267	B. WING				27/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION			700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 F 441 SS=E	"NovoLog in unope NovoLog FlexPen F stored between 2° a freeze. Do not use or exposed to temp (98.6°F). After a via syringe has been p temperatures below days, but should not heat or sunlight." Sanofi-aventis Lant 8/2015, indicated L days at room tempe or unopened. Facility policy Stora instructed staff, "12 stored in the refrige date on the label fo first used. The open in refrigerator or at Outdated, contamir deteriorated medica cracked, soiled or v immediately remova according to proceed disposal" INFECTION CONT LINENS CFR(s): 483.80(a)((a) Infection prevent	S-032 dated 2006, indicated ned vials, cartridges, and Prefilled syringes should be and 8°C (36° to 46°F). Do not NovoLog if it has been frozen beratures that exceed 37°C al, cartridge, or Prefilled unctured, it may be kept at v 30°C (86°F) for up to 28 to be exposed to excessive the exposed to excessive the exposed to excessive antus could be stored for 28 erature if the vial was opened ge of Medication dated 5/16, . Insulin products should be trator until opened. Note the r insulin vials and pens when ned insulin vial may be stored room temperature 14. nated, discontinued or ations and those that are without secure closures are ed from stock, disposed of dures for medication ROL, PREVENT SPREAD, 1)(2)(4)(e)(f) tion and control program. tablish an infection prevention n (IPCP) that must include, at	F 4				12/6/17

Facility ID: 00522

If continuation sheet Page 55 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245267	B. WING				C 27/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST ANTH	IONY HEALTH & REH	ABILITATION		-	700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 55	F 4	41			
	investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin	l upon the facility assessment ig to §483.70(e) and following tandards (facility assessment					
		ds, policies, and procedures hich must include, but are not					
	possible communic	eillance designed to identify able diseases or infections ead to other persons in the					
		om possible incidents of ase or infections should be					
		ansmission-based precautions event spread of infections;					
	(iv) When and how resident; including b	isolation should be used for a out not limited to:					
	depending upon the involved, and (B) A requirement the least restrictive posi- circumstances.	uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility					

		AND HUMAN SERVICES			FORM	11/27/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED C
		245267	B. WING			27/2017
NAME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP C		
ST ANTH	IONY HEALTH & REH	IABILITATION				
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	disease or infected contact with resider contact will transmi (vi) The hand hygie by staff involved in (4) A system for rec under the facility's I actions taken by the (e) Linens. Person process, and transp spread of infection. (f) Annual review. annual review of its program, as necess This REQUIREMED by: Based on observed review, the facility f was maintained due (R150) observed due addition, the facility (mechanical standi residents for whom personal cares and the restroom next to This had the potent Garden court who to Findings include: R150 was observed Nursing assistant (I bathroom and attace	byees with a communicable skin lesions from direct ints or their food, if direct t the disease; and ane procedures to be followed direct resident contact. cording incidents identified IPCP and the corrective e facility. nel must handle, store, bort linens so as to prevent the The facility will conduct an a IPCP and update their sary. NT is not met as evidenced tion, interview and document ailed to ensure hand hygiene ring cares for 1 of 4 residents uring personal cares. In failed to ensure EZ Stand ng lift) was cleaned between the lift was used to assist with to ensure it was not stored in o the garden court dayroom. tial to affect all 5 residents on	F 4	 F441 F441 Infection Control 1. The facility Infection Cont procedures has been review 2. Staff will be in-serviced on Control (hand washing and g cleaning of mechanical lifts 2567 survey examples. 3. The nursing leadership w hand washing and gloving c on 5 nursing staff per week have been completed. 4. The mechanical lifts will b weekly to ensure PDI wipes 5. The Director of Nursing w completed audits and bring concerns to the facility QAP 	ved n Infection glove use) and using specific ill complete ompetencies until all staff be audited are in place. vill review any identified	

Facility ID: 00522

If continuation sheet Page 57 of 66

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES		LE CONSTRUCTION		E SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	â		/PLETED	
		245267	B. WING			C / 27/2017	
NAME OF	PROVIDER OR SUPPLIER	240201		STREET ADDRESS, CITY, STATE, ZIP CODE		21/2017	
	IONY HEALTH & REH	IABILITATION	:	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	-		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 441	NA-B washed hand stood R150 utilizing bathroom. There w back of the residen pants down and ren R150 had saturated had soft brown stoo NA-B wiped the sto the toilet. NA-B ren and obtained clean gloves on and rend which were wet and them on the floor b changing gloves or clean pants on R15 the toilet, NA-B use to stand R150 up. N NA-B washed R150 stool on it. There w toilet seat. NA-B pu on R150 and pulled removed gloves an adjusted the EZ sta waist. RN-C positio her and NA-B move lowered R150 into not been wiped out had evidence that u cushion. RN-C rend hands before taking lounge. NA-B rend and put it against th NA-B washed hand loose soiled clothin hands and took it to	red Nurse (RN)-C arrived, ds and put on gloves. NA-B g the mechanical lift in the rere two large wet spots on the tt's pants. NA-B pulled R150 moved incontinence brief. d the incontinence pad and ol coming out of her rectum. ool away and sat resident on noved gloves washed hands a pants for R150. NA-B put oved R150's soiled pants d had stool on them and put y the bathroom door. Without washing hands, NA-B put 50. When R150 was done on ed EZ stand lift hand controls With the same pair of gloves 0's bottom, which had brown vas also brown stool on the ut a clean incontinence product d R150's pants up. NA-B and harness around R150's oned R150's wheelchair under ed EZ stand closer to chair and R150's Broda chair. Chair had t even though R150's pants urine had leaked through to the noved gloves and washed g R150 out to the television oved EZ stand from Bathroom he wall outside, the bathroom. ds and then picked R150's ing up off the floor with bare o the soiled utility room. NA-B	F 441	for further recommendations. 6. The Director of Nursing rem responsible for compliance wit requirement to ensure a safe, s and comfortable environment t the development and transmise disease and infection.	n this sanitary, o prevent		

If continuation sheet Page 58 of 66

		AND HUMAN SERVICES				FORM	11/27/2017 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	COM	E SURVEY PLETED
		245267	B. WING				C 27/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	IABILITATION			700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ige 58	F 4	41			
	 8/2/17, indicated R Alzheimer's disease cognitive portion of noted R150 was an activities of daily liv frequently incontine R83 was observed NA-B and RN-D too brought in the EZ s wiped down after it RN-D washed hand and RN-D put same for R150 on R83 an R83 up pulled down wet incontinence pain incontinence cares change gloves and clean incontinence R83's pants up and wheelchair. RN-D a washed hands. RN hands and then too to the dining room. bathroom. The EZ after usage. R83's annual MDS had dementia, and cognitive portion of noted R83 was an a and R83 was frequ and bowel. On 10/25/17, at 2:0 	inimum Data Set (MDS) dated, 150 had dementia and e, and could not complete the the MDS. The MDS further nextensive assist with all ing (ADLs) and R150 was ent of bladder and bowel. on 10/25/17, at 1:57 p.m. ok R83 to the bathroom. NA-B tand lift, which had not been was used for R150. NA-B and ds and put on gloves. NA-B e harness that had been used nd stood R83 up. NA-B stood n pants and removed R83's ad. NA-B preformed and was cued by RN-D to wash hands prior to putting a product on R83. NA-B pulled thelped R83 to sit in the and NA-B removed gloves and -D assisted R83 to hash ok resident out of the bathroom The EZ stand was left in the stand was not wiped down dated, 9/20/17, indicated R83 could not complete the the MDS. The MDS further extensive assist with all ADLs ently incontinent of bladder					

Facility ID: 00522

If continuation sheet Page 59 of 66

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED	
						(C	
		245267	B. WING			10/:	27/2017	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	ONY HEALTH & REH	ABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	CORRECTION (X5)		
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLÉTION DATE	
F 441	Continued From pa	ae 59	F 4	41				
	•	e bathroom. Two unknown		•••				
		wed R97 into the bathroom						
	and shut the door. bathroom.	The EZ stand remained in the						
		S dated 7/19/17, indicated						
		and was severely cognitively						
		further noted R97 was an hall activities of daily living						
	(ADLs) and R97 wa	as frequently incontinent of						
	bladder and bowel.							
		10/25/17, at 2:07 p.m. NA-B would wash her hands after						
	removing gloves bu	It was nervous and must have						
		ified she wiped down the toilet wn the EZ stand. NA-B stated						
		wn the EZ stand a couple of						
		ift. NA-B verified she did not						
	wipe down the EZ s	stand between residents.						
		10/25/17, at 2:22 p.m. RN-C						
		ot change gloves after doing efore putting a clean						
	incontinence produ	ct on or doing any other cares.						
		should have washed her						
		ng gloves and before touching hine. RN-C stated NA-B						
	should have worn g	loves, and put the soiled						
		before taking them to the						
	soiled utility room.							
		10/25/17, at 2:49 p.m. RN-D						
		t after pericare, staff would wash their hands. RN-D						
		o be wiped down after every						
	use.							
	During interview on	10/26/17, at 2:32 p.m. the						

If continuation sheet Page 60 of 66

		AND HUMAN SERVICES			FORM): 11/27/2017 1 APPROVED 9. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245267	B. WING		10	C / 27/2017
NAME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COL		
ST ANTH	IONY HEALTH & REH	ABILITATION		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 441 F 465 SS=E	remove gloves and pericare. The DON to touch a resident' lift belt after removi been washed. The lifts were to be wipe every resident use Mechanical lift clea provided. Hand Hygiene polic staff, "1. hand hygie after contact with re contaminated envir the resident e. Af residents with toilet bedpans, catheters clothsi. Before pe procedure and afte wornm. After cor oral secretions, mu skin." SAFE/FUNCTIONA E ENVIRON CFR(s): 483.90(i)(5 (i) Other Environme The facility must pr sanitary, and comfor residents, staff and (5) Establish policie applicable Federal, regulations, regardi	(DON), stated staff were to wash hands after providing stated it was not appropriate s clothing, a mechanical lift or ng gloves if hands had not DON stated that mechanical ed down with sanitizer after and daily by housekeeping. ning policy requested but not cy approved 10/6/17, instructs ene requirements: Before and esidents. c. After contact with onmental surfaces adjacent to ter toileting or assisting ing, handling of urinals, , soiled linens, towels wash erforming a resident care ADL r removal of gloves if ntact with blood, urine feces, cous membranes or broken AL/SANITARY/COMFORTABL	F 4			12/6/17

Facility ID: 00522

If continuation sheet Page 61 of 66

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		245267	B. WING			(
		243207	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/2	27/2017
NAME OF I	PROVIDER OR SUPPLIER						
ST ANTH	ONY HEALTH & REH	ABILITATION		-	700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	∃	(X5) COMPLETIO DATE
F 465	Continued From pa	ge 61	F 4	65			
	non-smoking reside	•					
	Based on observat review, the facility fa environment for 10	tion, interview, and document ailed to ensure a sanitary of 11 residents (R271, R110, 5, R267, R191, R34, R45).			F465 Safe/Functional/Sanitary/Comfortable Environment		
	Findings include:				 1. 10 out of 10 resident environmental concerns were immediately addressed 2. Each resident room and resident 	-	
	to hospital by 911 o The admission diag disease, dementia, food safely) with fee to communicate, his kidney cancer with Foley catheter. R27	1 12/3/16, and discharged back on 4/3/17 per the Face Sheet. In the fa			 bathroom in the facility was reviewed for cleanliness. 3. Each resident wheelchair was review for cleanliness and repair. 4. Each resident grab bar was reviewer ensure material is intact. 5. Each resident call light has been audited for function and placement. 6. Each resident room has been check 	wed d to	
	use; was totally dep and eating (tube fee spouse complained seat, and unclean r	bendent on staff for dressing eding). On 4/3/17, R271's I of feces and urine on toilet oom.			for extra cable boxes. 7. Housekeeping policies were reviewe and all Housekeeping staff were re-educated on proper cleaning techniques.	ed	
	assessment on 8/1 impairment, and did extensive assistance transfers and toilet	al Minimum Data Set (MDS) 1/17, had moderate cognitive d not reject cares, and needed ce of two staff for bed mobility, use. On 10/24/17, at 9:07 a.m. s very hard to press to activate			 8. The housekeeping and maintenance department will conduct environmental audits of items #2-#5 weekly until the r facility QAPI meeting on 12/19/2017. 9. The facility QAPI committee will revi completed audit results and make furth 	next ew	
	length of the wall he wheelchair armrest covering which mad	om had paint off the entire eat register. R110's s were missing the vinyl de the wheelchair uncleanable.			recommendations. 10. The Executive Director remains responsible for compliance with this requirement, to ensure that residents a provided a safe, functional, sanitary, ar		
	indicated R40 was moderately severe	review dated 7/25/17, cognitively intact, had depression, and was upervision for cares. On			comfortable environment.		

Facility ID: 00522

If continuation sheet Page 62 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/27/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245267	B. WING			C 27/2017
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ABILITATION		700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	were tattered, with y uncleanable surface cushion remained u detached from the y would stand up, rea with multiple bevera the way to the call li on 10/24/17, registe aides should be che R40's room was ob a.m. R40's the surfa wheelchair arm res white padding were padding were expor- and appeared to be substance. During a tour on 10 maintenance direct director said surfac cleaned. R26's annual assess indicated R27 had s and needed extens bed mobility, transfa at 4:19 p.m. R26's of mattress. R26 was she can use it to ge p.m. licensed practi room as requested R26. R14 was admitted S On 10/24/17, at 9:5 was not kept clean	ge 62 m. R40's wheelchair armrests vinyl missing making it an e. In addition, the wheelchair incleaned. R40's call light was wall. When he needed help he ich over the rolling tray table ages and items on it, blocking ight on the wall. At 10:00 a.m. ered nurse (RN)-H stated ecking for working call lights. served on 10/24/17, at 10:53 aces of both the manual ts were cracked and areas of clearly visible. More areas of sed on front of both armrests e soiled with a light brown /26/17, at 1:39 p.m. the acting or and the housekeeping e of the armrests could not be ssment dated 9/22/17, severely impaired cognition, ive assistance of two staff for ers and toilet use. On10/23/17, call light was trapped under unable to reach it. R26 stated at staff. On 10/23/17, at 4:19 ical nurse (LPN)-C came into and put the call light close to 0/25/17, per the Face Sheet. 0 a.m. R14 stated the sink in the bathroom. Staff clean dirty fast and "I cannot use the	F 465			

If continuation sheet Page 63 of 66

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2017 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245267	B. WING	i			C 27/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST ANTH	IONY HEALTH & REH	ABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	sink when it's dirty to There was missing heater. R45's quarterly MD indicated R45 was of extensive assistance transfers and toilet the grab bars on the and were no longer R267 was admitted the Face Sheet. On R267 stated sometic clean, "like today I w clean, I told staff and come in and clean i R191's re-admissio 9/12/17, indicated F with minimal depress assistance of two si and toilet use. On 1 was a medium size base. R34's quarterly revi indicated R34 was of depression, and ne- staff for bed mobility R34's room was ob approximately 7:00 observed to contain by two cables appro- wall, about two feet	S review dated 8/25/17, cognitively intact, needed e of two staff for bed mobility, use. On 10/23/17, at 7:47 p.m. bed had foam peeling off a cleanable surface. to the facility on 10/11/17, per 10/24/2017, at 11:07 a.m. mes the bathroom was not valked in there and it wasn't d housekeeping came had to	F	465			

If continuation sheet Page 64 of 66

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	• •				PLETED
		245267	B. WING				C 27/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST ANTH	IONY HEALTH & REH	ABILITATION		-	700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
			1		DEFICIENCY)		
F 465	Continued From pa	ge 64	F 4	65			
	R34 was interviewe	d at the time of the					
		id some man had left it there re for months. R34 said the					
	man had given her	a television remote. R34					
	picked up the remo wrapped in plastic.	te from her bedside stand, still					
		nmunications dated 5/12/17,					
		ice director to the facility ited cable instillation was to 12, 2017.					
	approximately 7:00 grab bar was obser	served on 10/23/17, at p.m., R45's bed right side ved to have foam on the top of ped, with approximately three					
	maintenance direct	/26/17, at 1:39 p.m. the acting or and the housekeeping e of the grab bar could not be					
	ceiling vents near the were noted to have surfaces of all of the	proximately 7:00 p.m., the ne fire door on 2 North unit a fine gray substance on the e grates in each vent. The as noted on the ceiling tiles vents.					
	housekeeping direct staff should have cl housekeeping direct housekeeping staff	on 10/25/17, at 2:18 p.m., the stor said the housekeeping eaned the ceiling vents. The stor said a member of the should have notified the tment about the wheelchair					

Facility ID: 00522

If continuation sheet Page 65 of 66

PRINTED: 11/27/2017

		AND HUMAN SERVICES				FORM	: 11/27/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245267	B. WING	à			C 27/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST ANTH	IONY HEALTH & REH	ABILITATION			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	arms, the damaged hanging from the w director said the ho resident areas as p schedule and were maintenance depar identified and leave Maintenance Conne maintenance Conne maintenance work During an interview the acting director of checked the Mainte compiled a list of w orders were stored list or work orders w dating back three m During an interview 10/26/17, at 9:31 a. maintenance depar orders. After review orders and said she work orders been p The Maintenance V policy and Procedu instructed any emp	A side rail and the cable box all. The housekeeping usekeeping staff inspected art of their daily cleaning instructed to call the tment if a concern was a voicemail message on the ection line to initiate order. on 10/25/17, at 10:53 a.m., of maintenance said she enance Connect line daily and ork orders. She said the work in this list until completed. A was provided, with work orders nonths.	F	465			

If continuation sheet Page 66 of 66



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 15, 2017

Ms. Claire Carpenter, Administrator St. Anthony Health & Rehabilitation 3700 Foss Road Northeast St Anthony, MN 55421

Re: State Nursing Home Licensing Orders - Project Numbers S5267020, H5267080, H5267081

Dear Ms. Carpenter:

The above facility was surveyed on October 23, 2017 through October 27, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5267080 and H5267081. The investigation of complaint number H5267080 was found to be unsubstantiated and investigation of complaint H5267081 was found to be substantiated at §144.651 Subd 15 and §626.557 Subd 17 (A-C). 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

St Anthony Health & Rehabilitation November 15, 2017 Page 2

"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 Gloria Derfus, Unit Supervisor at 651-201-3792 or gloria.derfus@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

Minnesc	ota Department of He	alth				
-		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
	IDENTIFICATION NUMBER: A. BUILDING: 10 00522 B. WING 10 ARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ANTHONY HEALTH & REHABILITATION 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION BE (EACH OPROPRIATE DEFICIENCY) 2 000 Initial Comments 2 000 2 000 *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessement of a fine even if the item that was violated during the) 7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	ARII ITATION				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	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	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. hether a violation has been compliance with all e rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm. The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 11/21/17

Electronically Signed

STATE FORM

If continuation sheet 1 of 62

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00522		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/27/2017				
			ADDRESS, CITY, STATE, ZIP CODE						
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST SS ROAD NOF						
ST ANTH	IONY HEALTH & REF		IONY, MN 554						
(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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
2 000	Continued From pa	age 1	2 000						
	you electronically. is necessary for Sta enter the word "cor text. You must ther State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for in indicate in the electronic cess, under the heading he date your orders will be electronically submitting to the nent of Health.							
	On October 23rd through October 27th, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	ı							
	the State Licensing federal software. Ta	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for							
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.							
	FOURTH COLUM	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.							

Minnesc	ta Department of He	ealth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	SURVEY _ETED
		BENTH IO/THOM NOWBER.	A. BUILDING	:		
		00522	B. WING		C 10/2	; 7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REF	IARII ITATION	S ROAD NO			
		SIANIH	ONY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Continued From pa	age 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORRE	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF TE STATUTES/RULES.				
	H5267081 were co survey. Complaint substantiated. Com	complaints H5267080 and mpleted at the time of the H5267080 was not npliant H5267081 was 44.651 Subd. 15, and 7 (A-C).				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/6/17
		omprehensive plan of care I personnel involved in the t.				
	This MN Requirem	ent is not met as evidenced				
	review, the facility f	ion, interview and document failed to follow the plan of care (R29) reviewed for urinary		 Resident R29 s care plans and sheets reviewed and revised as new reflect current bladder incontinence Other residents will have their To care plans updated with each quart 	eded to status. ileting	
	Findings include:			annual, or significant change of cor MDS.	ndition	
	diagnoses of deme disturbance and os Minimum Data Set indicated absence	ated 10/2013, indicated current entia without behavioral steoarthritis. R29's annual (MDS) dated 8/23/17, of spoken words regarding severely impaired cognition.		 Staff will be in-serviced on follow care plan interventions/NAR assign sheets and toileting schedules usin specific survey findings as an exam Nursing leadership will complete toileting competencies on 8 staff per 	iment g iple.	

If continuation sheet 3 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		00522	B. WING		(10/2) ?7/2017
	PROVIDER OR SUPPLIER	STREET A		STATE, ZIP CODE	• • • •	
		3700 FO	SS ROAD NO			
ST ANTH	IONY HEALTH & REF		IONY, MN 5			
(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 ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 3	2 565			
	transfer to or from person extensive a cleansing self after R29's care area as communication, da is never/rarely under does not speak and incontinence and in R29 was frequently extensive assist of not able to manage pads, or take care R29's care plan, ef present, indicated n and bladder function incontinence of box staff to offer toiletin meals, HS (at bedt and PRN (as need	nsive assist of one person to bed, chair, wheelchair and one assist for toilet use including relimination and pad changes. sessment (CAA) for ted 9/1/17, indicated resident erstood verbally and resident d is deaf. CAA for urinary ndwelling catheter indicated / incontinent, required one staff for toileting and was e incontinence, change her of own pericares. fective date 10/30/17, to resident's alteration in bowel on due to dementia, frequent wel and bladder directed facility ing upon rising, before/after ime), NOC (at night) rounds ed) AX1 (assist times 1). AX1 nd pericare after incontinence		until all NAR staff have be 5. The facility QAPI common completed toileting compe- and make further recommon 6. See also F312 7. The Director of Nursing responsible for compliance requirement, to ensure the provided in accordance we resident s plan of care.	hittee will review etency results hendations. g remains the with this at services are	
	indicated R29 was bladder, was to offe	en Court NAR Report Sheet, not dated, ated R29 was incontinent of bowel and der, was to offer toileting upon rising, re/after meals, HS, NOC rounds and PRN				
	7:18 a.m. to 10:29 -At 7:18 a.m., R29 dining room via wh -From 8:08 a.m. to eating breakfast wi Garden Court day	8:58 a.m., R29 was observed th staff assist, then brought to	t			
	observed to place t	the gait belt around the R29's R29 from wheelchair to day				

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		C	
		00522	B. WING		10/	27/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' 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 THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ae 4	2 565			
	eyes closed in the o -From 9:49 a.m. to and observed watch with staff. -From 10:29 a.m. to sit in day room chain During an interview when asked NA-B i incontinence care w the bathroom when further stated that F hours and does not dry when she took f verified she had no reference to toiletin that NA-A "felt to se transferred her to th her down. You can During an interview when asked to deso for incontinence NA bottom to make sur resident was transfe day room. During an interview when asked what h	10:12 a.m., R29 was awake hing television and interacting o 10:41 a.m., R29 continued to				
	expected a pad che RN-D further stated center of the pad w tell, can see visually reference to how to	follow the care plan and eck, prefer to check in private. I there are markings on the hich changes color, "you can y on the outside of the pad" in check saturation on the RN-D stated she would prefer				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		BERTH TOXITOT TOMBET.	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·			
		00522	B. WING			C 27/2017	
ME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
Γ ΑΝΤΗ	ONY HEALTH & REH		SS ROAD NOF				
	SI IMMARY ST		IONY, MN 554	PROVIDER'S PLAN OF ((X5)	
X4) ID REFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLE DATE	
2 565	Continued From pa	age 5	2 565				
	(DON) when asked check R29's incont	with the director of nursing d if she would expect staff to inence pad in the day room, expect them to do it in a private					
		llowing the care plan was tled "Comprehensive Care					
	The administrator of system to educate	THOD OF CORRECTION: or designee could develop a staff and develop a monitoring taff are providing care as ten plan of care.	J				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	9				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			12/6/17	
	receive nursing can custodial care, and individual needs an the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be our possible unless there is a the attending physician that the ain in bed or the resident n bed.	d t				
	This MN Requirem	ent is not met as evidenced					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00522	B. WING		C 10/2	; 7/2017
AME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
		3700 FOS	SS ROAD NO	DRTHEAST		
IANIH	ONY HEALTH & REH	ABILITATION ST ANTH	ONY, MN 5	5421		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH		(X5) COMPLE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE API DEFICIENCY)		DATE
2 830	Continued From pa	age 6	2 830			
	by:					
		tion, interview and document		1. Resident R29 s care plans		
		failed to ensure 1 of 5 residents to was dependent on staff	5	sheets reviewed and revised a reflect current bladder incontin		
		leting, received care and		2. Other residents will have the		
	services in a timely			care plans updated with each of	quarterly,	
				annual, or significant change o	f condition	
	Findings include:			MDS. 3. Staff will be in-serviced on fo	llowing	
	R29's face sheet d	ated 10/2013, indicated		care plan interventions/NAR as		
		g: dementia without behavioral		sheets and toileting schedules	•	
	0	steoarthritis. R29's annual		specific survey findings as an e		
		(MDS) dated 8/23/17,		4. Nursing leadership will comp		
		ent had an absence of spoken		toileting competencies on 8 sta		
		peech clarity and had severely		until all NAR staff have been construction 5. The facility QAPI committee		
		. R29 required extensive assist ansfer to or from bed, chair, or		completed toileting competence		
		quired extensive assist of one		and make further recommendation		
		e including cleansing self after		6. See also F282		
		d changes. R29's care area		7. The Director of Nursing rem		
) for communication, dated		responsible for compliance wit		
		ne resident was never/rarely		requirement, to ensure that res		
		y, did not speak and was deaf. continence and indwelling		receive the appropriate treatme services to improve/maintain A		
		R29 was frequently incontinent.			DLO.	
		assist of one staff for toileting	, 			
		o manage incontinence,				
	change her pads, o	or take care of own pericares.				
	R29's care plan of	fective date 10/30/17, to				
		resident's alteration in bowel				
		on due to dementia, frequent				
		wel and bladder directed facility	'			
		ng upon rising, before/after				
		time), NOC (at night) rounds				
		ed) AX1 (assist times 1). AX1 nd pericare after incontinence				
	every shift.	na pondare aller moontimende				
		NA (nursing opciators) Doment				
	The Garden Court	NA (nursing assistant) Report				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
		00522	B. WING			C 0/27/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554				
(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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 7	2 830				
	of bowel and blade	ndicated R29 was incontinent ler, was to offer toileting upon meals, HS, NOC rounds and					
	7:18 a.m. to 10:29 -At 7:18 a.m., R29 dining room via wh -From 8:08 a.m. to eating breakfast wi Garden Court day -At 9:02 a.m., nurs observed to place waist, transferred F room chair. -From 9:24 a.m. to eyes closed in the -From 9:49 a.m. to and observed watch with staff.	8:58 a.m., R29 was observed ith staff assist, then brought to room by staff. ing assistant (NA)-A was the gait belt around the R29's R29 from wheelchair to day 9:47 a.m., R29 observed with day room. 10:12 a.m., R29 was awake ching television and interacting o 10:41 a.m., R29 continued to					
	when asked NA-B incontinence care with the bathroom when further stated that hours and does no dry when she took verified she had no reference to toiletin that NA-A "felt to se transferred her to t	v on 10/25/17, at 10:41 a.m., if R29 was offered or if was done stated "I'll take her to n I get back from break." NA-B R29 usually goes every three t void much and was usually her to the bathroom. NA-B ot taken R29 that morning, in ng R29. NA-B further stated ee if she was dry before she he other chair, before she sat usually tell if the pad is heavy.					
	when asked to des	v on 10/25/17, at 10:55 a.m., cribe how R29 was checked A-A indicated she "padded her					

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		A. BUILDING.			С
	00522	B. WING			0 27/2017
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ONY HEALTH & REF					
SUMMARY STATEMENT OF DEFICIENCIES		ID			(X5) COMPLE
		TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
Continued From pa	age 8	2 830			
		9			
when asked what h for incontinence ca stated staff should further stated there the pad which char see visually on the	ner expectations of staff was ure, registered nurse (RN)-D follow the care plan. RN-D e are markings on the center of nges color, "you can tell, can outside of the pad" in				
12/6/12, indicated t Care and Comfort resident clean, dry hours and/or at pre maintain the reside prevent skin break The policy further in be checked, toilete	that "Scheduled Incontinent consists of keeping the and comfortable every two edetermined intervals, to ent in a clean and dry state to down such as excoriations." ndicated that "The resident will d and/or changed every two				
The director of nurs all residents depending incontinence are re- treatment/services. designee, could co- delivery of care to e	sing or designee, could ensure ident with care for their eceiving the necessary . The director of nursing or nduct random audits of the ensure appropriate care and				
TIME PERIOD FO	R CORRECTION: Twenty-one				
	PROVIDER OR SUPPLIER ONY HEALTH & REF SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pa bottom to make su resident was transf day room. During an interview when asked what h for incontinence ca stated staff should further stated there the pad which char see visually on the reference to how to incontinence pad. Facility policy titled 12/6/12, indicated for Care and Comfort resident clean, dry hours and/or at pre- maintain the reside prevent skin break The policy further i be checked, toilete hours. It may be m is present." SUGGESTED MET The director of nur- all residents depen- incontinence are re- treatment/services designee, could co delivery of care to o	OF CORRECTION IDENTIFICATION NUMBER: 00522 00522 PROVIDER OR SUPPLIER STREET AI ONY HEALTH & REHABILITATION 3700 FO: ST ANTH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IDENTIFYING INFORMATION) Continued From page 8 bottom to make sure that she was dry" before resident was transferred to the regular chair in the day room. Interview on 10/25/17, at 11:11 a.m., when asked what her expectations of staff was for incontinence care, registered nurse (RN)-D stated staff should follow the care plan. RN-D further stated there are markings on the center of the pad which changes color, "you can tell, can see visually on the outside of the pad" in reference to how to check saturation on the incontinence pad. Facility policy titled "Incontinence Care" dated 12/6/12, indicated that "Scheduled Incontinent Care and Comfort consists of keeping the resident clean, dry and comfortable every two hours and/or at predetermined intervals, to maintain the resident in a clean and dry state to prevent skin breakdown such as excoriations." The policy further indicated that "The resident will be checked, toileted and/or changed every two hours. It may be more frequent if skin breakdown is present." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could ensure all residents dependent with care for their incontinence are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00522 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 8 2 830 bottom to make sure that she was dry" before resident was transferred to the regular chair in the day room. 2 830 During an interview on 10/25/17, at 11:11 a.m., when asked what her expectations of staff was for incontinence care, registered nurse (RN)-D stated staff should follow the care plan. RN-D further stated there are markings on the center of the pad which changes color, "you can tell, can see visually on the outside of the pad" in reference to how to check saturation on the incontinence pad. Facility policy titled "Incontinence Care" dated 12/6/12, indicated that "Scheduled Incontinent Care and Comfort consists of keeping the resident clean, dry and comfortable every two hours and/or at predetermined intervals, to maintain the resident in a clean and dry state to prevent skin breakdown such as excoriations." The policy further indicated that "The resident will be checked, toileted and/or changed every two hours. It may be more frequent if skin breakdown is present." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could ensure all residents dependent with care for their incontinence are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00522 B. WING 'ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST STANTHONY, MN 55421 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY WIST BE PRECEDED BY FULL ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 8 2 830 bottom to make sure that she was dry" before resident was transferred to the regular chair in the day room. 2 830 During an interview on 10/25/17, at 11:11 a.m., when asked what her expectations of staff was for incontinence care, registered nurse (RN)-D stated staff should follow the care plan. RN-D further stated there are markings on the center of the pad which changes color, "you can tell, can see visually on the outside of the pad" in reference to how to check saturation on the incontinence pad. Facility policy titled "Incontinence Care" dated 12/6/12, indicated that "Scheduled Incontinent Care and Comfort consists of keeping the resident chan, dry and comfortable every two hours and/or at predetermined intervals, to maintain the resident in a clean and dry state to prevent skin breakdown such as excoriations." The policy further indicated that "The resident will be checked, toileted and/or changed every two hours. It may be more frequent if skin breakdown is present." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could ensure all resident scient with care for their incontinence are receiving the necess	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00522 B. WING 10/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST STANTHONY, MN 5521 SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-ROED OF THE ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-ROED TO THE APPROPRIATE DEFICIENCY) Continued From page 8 2 830 2 830 During an interview on 10/25/17, at 11:11 a.m., when asked what her expectations of staff was for incontinence care, registered nurse (RN)-D stated staff should follow the care plan, RN-D further stated there are markings on the center of the pad which changes color, You can tell, can see visually on the outside of the pad" in reference to how to check saturation on the incontinence pad. Facility policy titled "Incontinence Care" dated 12/6/12, indicated that "Scheduled Incontinent Care and Confort consist of keeping the resident clean, dry and comfortable every two hours and/or at predetermined intervals, to prevent skin breakdown such as excoriations." The policy further indicated that "The resident will be checked, toileted and/or changed every two hours. It may be more frequent if skin breakdown is present." SUGGESTED METHOD OF CORRECTION: The director of nursing or de

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00522	B. WING		0 10/2) 7/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		3700 EQ5	S ROAD NO			
ST ANTH	IONY HEALTH & REH	IARII ITATION	ONY, MN 5			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
21375	Continued From pa	age 9	21375			
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			12/6/17
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observatives is the facility of the facility of the facility of the facility of the facility (mechanical standives) addition, the facility (mechanical standives) and the facility (mechanical standives) and the restroom next of the restroom. There we back of the resident of the restroom next of the restroom. There we back of the restroom next of the re	ent is not met as evidenced ion, interview and document ailed to ensure hand hygiene ring cares for 1 of 4 residents uring personal cares. In failed to ensure EZ Stand ng lift) was cleaned between the lift was used to assist with to ensure it was not stored in o the garden court dayroom. tial to affect all residents on on 10/25/17, at 1:38 p.m. NA)-B took R150 to the ched the EZ stand lift ng lift) harness around R150's red Nurse (RN)- C arrived, ds and put on gloves. NA-B g the mechanical lift in the ere two large wet spots on the t's pants. NA-B pulled R150 moved incontinence brief.		 The facility Infection Control pol procedures has been reviewed Staff will be in-serviced on Infect Control (hand washing and glove cleaning of mechanical lifts using 2567 survey examples. The nursing leadership will com hand washing and gloving compet on 5 nursing staff per week until a have been completed. The mechanical lifts will be aud weekly to ensure PDI wipes are in 5. The Director of Nursing will revit completed audits and bring any id concerns to the facility QAPI comp for further recommendations. The Director of Nursing remains responsible for compliance with the requirement to ensure a safe, san and comfortable environment to p the development and transmission disease and infection. 	ction use) and specific pplete tencies Il staff ited place. ew entified mittee s is itary, revent	
	had soft brown stoo NA-B wiped the sto the toilet. NA-B rem	d the incontinence pad and ol coming out of her rectum. ool away and sat resident on noved gloves washed hands pants for R150. NA-B put				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	0. 00	A. BO		A. BUILDING:			
		00522	B. WING	B. WING		C 10/27/2017	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST ANTH	IONY HEALTH & REF	ARII ITATION	SS ROAD NOF IONY, MN 554				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21375	Continued From pa	age 10	21375				
	which were wet and them on the floor b changing gloves or clean pants on R15 the toilet, NA-B use to stand R150 up. NA-B washed R150 stool on it. There w toilet seat. NA-B pu on R150 and pulled removed gloves an adjusted the EZ sta waist. RN-C position her and NA-B move lowered R150 into not been wiped out had evidence that of cushion. RN-C rem hands before taking lounge. NA-B remo and put it against th NA-B washed hand loose soiled clothin hands and took it to returned to the batt the toilet seat of an NA-B removed glove R150's quarterly M 8/2/17, indicated R Alzheimer's diseas cognitive portion of noted R150 was ar activities of daily liv frequently incontine R83	oved R150's soiled pants d had stool on them and put y the bathroom door. Without washing hands, NA-B put 50. When R150 was done on ed EZ stand lift hand controls With the same pair of gloves 0's bottom, which had brown vas also brown stool on the ut a clean incontinence product d R150's pants up. NA-B id without washing her hands, and harness around R150's oned R150's wheelchair under ed EZ stand closer to chair and R150's Broda chair. Chair had t even though R150's pants urine had leaked through to the noved gloves and washed g R150 out to the television oved EZ stand from Bathroom he wall outside, the bathroom. ds and then picked R150's ing up off the floor with bare to the soiled utility room. NA-B hroom and put gloves on wiped id then sanitized the toilet seat ves and washed hands. inimum Data Set (MDS) dated 150 had dementia and e, and could not complete the the MDS. The MDS further in extensive assist with all ring (ADLs) and R150 was ent of bladder and bowel.	Э				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		A. BOILDING				С	
		00522	B. WING			27/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
T ANTH	ONY HEALTH & REH		SS ROAD NOF IONY, MN 554				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE ⁻ DATE	
21375	Continued From pa	age 11	21375				
	was used for R150 hands and put on g same harness that R83 and stood R83 pulled down pants incontinence pad. I cares and was cue and wash hands pr incontinence produ pants up and helpe RN-D and NA-B re hands. RN-D assis then took resident dining room. The EZ after usage.	d not been wiped down after it . NA-B and RN-D washed gloves. NA-B and RN-D put had been used for R150 on 3 up. NA-B stood R83 up and removed R83's wet NA-B preformed incontinence d by RN-D to change gloves rior to putting a clean uct on R83. NA-B pulled R83's ed R83 to sit in the wheelchair. moved gloves and washed ted R83 to hash hands and out of the bathroom to the EZ stand was not wiped down					
	had dementia, and cognitive portion of noted R83 was an	dated, 9/20/17, indicated R83 could not complete the the MDS. The MDS further extensive assist with all ADLs ently incontinent of bladder					
	bathroom. EZ stan down was still in th staff members follo	5 p.m. R97 walked into the d which had not been wiped e bathroom. Two unknown owed R97 into the bathroom The EZ stand remained in the					
	R97 had dementia impaired. The MDS extensive assist wi	OS dated 7/19/17, indicated and was severely cognitively S further noted R97 was an th all activities of daily living as frequently incontinent of					
	Durina interview or	n 10/25/17, at 2:07 p.m. NA-B					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			С
		00522	B. WING			27/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
T ANTH	IONY HEALTH & REF	ARII ITATION	SS ROAD NOF IONY, MN 554			
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 12	21375			
	removing gloves bu forgotten. NA-B ver but did not wipe do staff would wipe do times during the sh wipe down the EZ s During interview or verified NA-B did n pericare for R150 k incontinence produ RN-C stated NA-B hands after removi resident or the mad should have worn g	would wash her hands after ut was nervous and must have rified she wiped down the toiled wn the EZ stand. NA-B stated own the EZ stand a couple of nift. NA-B verified she did not stand between residents. In 10/25/17, at 2:22 p.m. RN-C ot change gloves after doing before putting a clean lot on or doing any other cares should have washed her ng gloves and before touching chine. RN-C stated NA-B gloves, and put the soiled before taking them to the				
	stated would expect remove gloves and	n 10/25/17, at 2:49 p.m. RN-D ct after pericare, staff would I wash their hands. RN-D to be wiped down after every				
	director of nursing remove gloves and pericare. The DON to touch a resident lift belt after removi been washed. The lifts were to be wipe	n 10/26/17, at 2:32 p.m. the (DON), stated staff were to I wash hands after providing I stated it was not appropriate I's clothing, a mechanical lift or ing gloves if hands had not DON stated that mechanical ed down with sanitizer after and daily by housekeeping.				
	Mechanical lift clea provided.	ning policy requested but not				
		cy approved 10/6/17, instructs ene requirements: Before and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
					С	
		00522	B. WING		10/	27/2017
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST SS ROAD NOR			
ST ANTH	IONY HEALTH & REH		IONY, MN 554			
(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
21375	Continued From pa	age 13	21375			
	contaminated envir the resident e. Af residents with toilet bedpans, catheters clothsi. Before p procedure and afte wornm. After cor	esidents. c. After contact with conmental surfaces adjacent to ter toileting or assisting sing, handling of urinals, s, soiled linens, towels wash erforming a resident care ADL r removal of gloves if ntact with blood, urine feces, scous membranes or broken				
	The director of nurs staff on the approp patient use equipm	THOD OF CORRECTION: sing or designee could educate riate cleaning of multiple ent to prevent cross then monitor for compliance.	2			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			11/17/17
	maintain a compre- infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines of States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines.				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00522	B. WING		C 10/2	, 7/2017
	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	-	
		3700 FOS	S ROAD NO			
ST ANTH	IONY HEALTH & REH		ONY, MN 55			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ige 14	21426			
	be maintained by th	ne nursing home.				
		ent is not met as evidenced				
	by:					
		and document review, the ure tuberculosis (TB) symptom		MN Rule 144A.04 TB screening		
	screening was com	pleted for 1 of 5 residents				
		ently admitted to the facility. In		Residents		
		failed to ensure 1 of 5 perculosis screening (chest		1. TB screening tool was complete	ed for	
	x-ray) had medical	doctor (MD) interpretation of		R27 on 9/7/17.		
	results to rule out a	ctive tuberculosis.		2. All other residents have had a T	В	
	Findings include:			screening completed. 3. Licensed Nurses will be re-educ the TB screening tool.	cated on	
	was no evidence in	to the facility on 8/24/17. There the medical record of a pms screening prior to TST		 A. Nursing leadership will audit ne admissions for completion of the screening tool. 		
		ed the first tuberculin skin test		5. The Director of Nursing will revi	ew	
		vith results read on 8/26/17, as		completed audits and bring any id		
		nduration. R27 received the /17, with results read on		concerns to the facility QAPI comr for further recommendations.	nittee	
		, 0 mm of induration. A TB		6. The Director of Nursing remains	S	
		as completed on 9/7/17, three		responsible to ensure new admiss	ions are	
	days after the seco	nd ISI.		screened for TB.		
	During interview on	10/27/17, at 7:40 a.m. the		Staff		
	director of nursing ((DON) verified the TB				
	symptom screen wa completed prior to t	as not and should have been		1. Employee E1 has a new chest scheduled for 11/21/2017.	k-ray	
				2. All other new employees hired i	n past 6	
		10/27/17, at 9:22 a.m.		months have been reviewed to en		
		N)-B verified a TB symptom		screening has been completed	Mark 11	
		eted on 9/7/17, after the nould have been completed		3. The facility has contracted with to complete all pre-employment en		
Vinnesota D	epartment of Health				inhioyee	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY
		00522	B. WING			C 2 7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		S ROAD NO			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 15	21426			
	prior to the first TS E-1's hire date was screen was comple 8/17/17, for E-1 ind [x-rays pass from fi [x-rays pass from b Strep - BMC," were indicated "Chest x- no indication E-1 re rule out active tube During interview or stated she was not completed to rule of was not a MD evalue Review of the facili 8/31/15, indicated a upon admission wit protein derivative) I testing (documentat Mantoux PPD (puri obtained within 90 policy lacked direct symptom screen. Review of the facili indicated all employ do not have TB bef with clients. The fac positive Mantoux, w indicates negative	T. 9/13/17. A TB symptom eted 9/13/17. A medical visit on licated "XR [X-ray] CHEST AP ront-to-back] or PA LATERAL back-to-front] and Throat Rapid completed. The report ray was normal." There was eceived a medical evaluation to rculosis. 10/27/17, at 9:22 a.m. RN-B sure if E1's chest x-ray was but active TB and verified there		chest x-rays for the facility. 4. The hiring managers have educated on pre-employments screening. 5. The facility HR manager was new employee files for appro- screening. 6. The Executive Director re- responsible to ensure all new are screened for TB.	nt TB will audit all opriate TB mains	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED	
		00522	B. WING	10/	C / 27/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY,	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NO HONY, MN 5			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE	
21426	Continued From pa	ge 16	21426			
	The Director of Nur monitor to assure to procedures were do	eveloped and implemented to ee of tuberculosis prior to nts. R CORRECTION:				
21495	Providing Social Se Subp. 5. Providing services must be p identified social ser according to the co assessment and co	5 Subp. 5 Social Services; ervices g social services. Social rovided on the basis of vice needs of each resident, mprehensive resident omprehensive plan of care 4658.0400 and 4658.0405.	21495		12/6/17	
	by: Based on observative review, the facility for assessment and set (R186) diagnosed waffecting activities of poor appetite. Findings include: R186's admission recertified nurse practive weighed 68.5 poun index) of 11.8. R186's admission of the set of	ent is not met as evidenced on, interview and document ailed to provide adequate ervices for 1 of 1 resident with mental illness symptoms of daily living (ADL) regarding note dated 5/19/15, by the titioner (CNP), indicated R180 ds and had a BMI (body mass diagnoses report dated iagnoses of bipolar disorder		 R186 was immediately offered psychology services, and refused. SS to continue to offer psychology services to resident at each care conference and PRN. All residents in the building were reviewed for appropriate of psychology services, and assessed by psychology as desired by resident. The facility has developed a psychology referral procedure. Social Service staff educated on the psychology referral procedure. All staff has been assigned the course mental health needs of the older adult in HCA for the month of December. 		

If continuation sheet 17 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		LETED
		00522	B. WING		(10/2) 27/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NO IONY, MN 5			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21495	Continued From pa	age 17	21495			
	clearly) and anorex characterized by se R186's care plan, e indicated R186 had related to poor app encourage oral inta appropriate. R186's clinical note dated 1/9/17, indica and social services as needed. R186's ADL verifica through 10/25/17, i a small percentage The Care Conferent indicated R186 refut had a poor intake a	effective 5/29/15 to current, d inadequate food intake betite and instructed staff to ake and intervene when e from the facility social worker ated R186 had a poor appetite would monitor and follow up ation worksheets dated 8/31/17 ndicated R186 consumed ate of one to two meals per day. hoce note dated 10/5/17, used dietary supplements and at meal time.		 All residents will continue reviewed for appropriate ps services during every care The facility QAPI commining residents receiving psycholic and make further recommending 8. The Executive Director responsible for compliance requirement, to ensure that receive social services to a maintain the highest praction mental and psychosocial we each resident. 	sychology conference. ttee will review logy services endations. emains with this t residents ttain or cable physical,	
	69.0 pounds. R186 followed up on per	Vs weight was documented as weight loss needs were not the social note of 1/9/17.				
	physician was inter remember writing a	0 a.m., R186's treating viewed and said he did not an order for a psychiatric e thought social services took				
	registered nurse (F	on 10/25/17, at 10:32 a.m. RN)-F said the physician der for a psychiatric consult ave an order for a				
	A clinical note data	d 10/25/17, during the survey				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED	
		00522	B. WING			0/27/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21495	process, at 12:08 p	m. indicated the facility social 86 and offered in-house	21495				
	During an interview on 10/26/17, at 9:02 a.m., the director of nursing (DON) said she expected psychiatric consultations would be offered to residents with psychiatric diagnoses and social services should have requested psychiatric consultation.						
	the facility dietician assessment of R18 the facility. The diet benefitted from a p understand why R1 dietician could not f	on 10/26/17, at 11:38 a.m., said she had not done an 6 nutrition, as she was new to tician stated R186 would have sychiatric consult to better 86 was not eating. The curren find evidence in the medical hal assessment being					
	dated 1/30/13, indic notified by nursing s intervention and nu order and notify soo	tled mental health services cated social services will be staff of need for mental health rsing is to acquire a doctor's cial services. It indicated socia the contracted mental health s.					
	The DON could con assessment to deter interventions to pro behavioral issues. A revised so that beh evaluated for effect An ongoing audit th	THOD OF CORRECTION: nduct a comprehensive ermine the appropriate vide for residents with A plan could be developed and avioral interventions could be civeness and revisions made. nat included all residents with could be reviewed at the quality neetings.					

Minnosc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00522	B. WING		- 10/2	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	ONY HEALTH & REH		S ROAD NOI ONY, MN 554			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLETE DATE
21495	Continued From pa	ge 19	21495			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21545	MN Rule 4658.1320	0 A.B.C Medication Errors	21545			12/6/17
	percent as describe Guidelines for Code 42, section 483.25 of the State Operation Surveyors for Long- incorporated by refe purposes of this par (1) a discrepar prescribed and wha administered to res (2) the adminis medications. B. It is free of a error. A significant (1) an error v discomfort or jeopa safety; or (2) medication requires the medication error report must be that occurs. Any sig- resident reactions n physician or the phy- resident or the resid designated represe- must be made in th	Ist ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident rdizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single uld alter that level and urrence of symptoms or ions are administered as ident report or medication error gnificant medication errors or nust be reported to the ysician's designee and the dent's legal guardian or ntative and an explanation e resident's clinical record. ons are administered as				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPL	
	00522		B. WING		C 10/27/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY.	STATE, ZIP CODE	•	
		3700 FOS	S ROAD NO			
ST ANTH	IONY HEALTH & REH		ONY, MN 5			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		COMPLET DATE
				DEFICIENCY)		
21545	Continued From pa	age 20	21545			
	prescribed An inc	ident report or medication error				
		d for any medication error that				
		cant medication errors or				
		must be reported to the				
		ysician's designee and the				
		dent's legal guardian or				
		entative and an explanation				
	must be made in th	ne resident's clinical record.				
	This MN Requirem	ent is not met as evidenced				
	by:					
	Based on observation, interview and document			1. The identified expired insulir	s were	
		failed to ensure residents were		removed from the med carts as		
		nedication errors for 4 of 20		notified about the concern during	g the	
		15, R127, R57) who received		annual survey.		
		ng insulin used for the		2. R221, R15, R127, and R57		
		ed blood sugars), and for 1 of vho received NovoLog (a short		a Medication Error Report comp notified, and insulin orders review		
		e treatment of elevated blood		Identified staff involved in these	veu.	
	sugars).	e liealment of elevated blood		medication errors were re-educa	ted on the	
				error as part of the medication e		
	Findings include:			report.		
	-			3. All other residents with an or		
		R221's five-day Minimum Data Set (MDS) dated		Insulin have had their insulin che	cked for	
		R221 was cognitively intact,		expiration dates.		
		ections seven days a week and		4. Licensed Nurses will be in-s		
		diabetes mellitus (a disease		medication administration and st	•	
	where blood sugar	s are too nign) with erve damage related to		5. Licensed Nurses have been education on medication administration		
	diabetes).	The damage related to		and Diabetes through Health Ca		
				Academy to be completed by 12		
	During medication	administration observation on		6. PharMerica Nurse Consulta		
		.m. licensed practical nurse		conduct a medication administra		
	(LPN)-C prepared	R221's Lantus 22 unit. The vial		storage audit on 11/28/17 and 11		
		ed as opened 9/18/17. Prior to		7. All Nurses will complete a m		
		21's room surveyor stopped		storage self competency each sl		
		n check the expiration date on		work until the next QAPI meeting	J	
	the vial. LPN-C ver	ified the Lantus was expired		12/19/17.		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	_ETED
00522		B. WING		C 10/2	, 7/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21545	Continued From pa	ge 21	21545			
	 45 Continued From page 21 and he had not been aware it was expired. LPN-C stated Lantus is only good for 28 days after it comes out of refrigeration, and should have been destroyed on 10/15/17. R221's October 2017 Medication Administration Records revealed R221 had an order dated 10/2/17, for Lantus 22 units daily. R221 received Lantus 22 units from 10/2/17 through 10/23/17. R221's blood sugars varied from 83 milligrams/deciliter(mg/dl) -217 mg/dl (normal range 70-100 mg/dl) during the period of time from 10/2/17, to 10/15/17. R221's blood sugars varied from 65 milligrams/deciliter(mg/dl) -217 mg/dl (normal range 70-100 mg/dl) during the period of time from 10/2/17, to 10/15/17. R221's blood sugars varied from 10/2/17, to 10/16 through 10/23/17. 		21545	 Nursing leadership will complete Medication administration competency assessments on 5 Nurses per week until all Nurses have been assessed. Nursing leadership will complete 5 medication storage competency audits weekly until the next QAPI meeting 12/19/17. The facility QAPI committee will review completed audits and medication error reports monthly and make further recommendations. See also F431. The Director of Nursing remains responsible to ensure residents are free of any significant medication errors. 		
	was moderately ind making, received in week and had a dia During medication of at 7:21 p.m. Lantus with a date open of vial had been dated stated Lantus was of stated R15 had rec Twenty-eight days f	S dated 9/9/17, indicated R15 lependent with decision agnosis of diabetes mellitus. cart observation on 10/23/17, a vial for R15 was observed 9/22/17. LPN-D verified the d as opened 9/22/17, and only good for 28 days. R15 eived Lantus that day. from 9/22/17, was 10/19/17.				
	Records revealed F 9/26/17, for Lantus Lantus 20 units fror R15 received Lantu days. R15's blood s	Il during the period of time				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	`́ СОМ	E SURVEY PLETED
		00522	B. WING		10/	27/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21545	Continued From pa	age 22	21545			
	R127's 30 day MDS dated 10/5/17, indicated R127 was cognitively intact, received insulin injections seven days a week and had a diagnosis of diabetes mellitus.					
	at 7:24 p.m. Lantus with a sticker on it t 9/17/17, and expira Registered nurse (I currently in the hos the hospital on 10/2 Lantus vial indicate	cart observation on 10/23/17, s vial for R127 was observed that indicated date open of ttion date of 10/15/17. RN)-G stated R127 was pital and had been admitted to 28/17. RN-G verified date on vd it had been opened 9/17/17, was only good for 28 days.				
	Records revealed F 10/9/17, for Lantus received Lantus 20	17 Medication Administration R127 had an order dated 20 units daily. R127 had units from 10/11-10/19/17. tus from an expired vial for pired.				
	indicated R127's La	report closed 10/25/17, antus vial was opened 9/17/17 een discarded 10/15/17.				
	R57 was severely of	S dated 9/20/17, indicated cognitively impaired received even days a week and had a es mellitus.				
	at 9:46 a.m. Lantus with a sticker on it t 9/21/17, LPN-E ver morning. LPN-E sta and for some reaso the Lantus vial was	cart observation on 10/24/17, s vial for R57 was observed that indicated date open of ified R57 received Lantus that ated she had given the Lantus on had not checked the date opened. LPN-E stated the via disposed of on 10/18/17.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		COM	E SURVEY PLETED
	00522		B. WING			C 27/2017
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(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 THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 23	21545			
	medication cart dat should have been of day on 10/18/17. L received NovoLog expired medication medication error. During interview or stated giving expire medication error. R57's October 201 Records revealed I for Lantus 20 units Lantus 20 units fro R57 received Lantu days after it expired Administration Reco order dated 9/18/11 times a day based 249 mg/dl. R57 hav Novolog insulin after During interview or Medical Director gi would be a medical During interview or director of nurses (expected the nurse any vial of insulin a not give the expired Lantus and NovoLog from the time they	n 10/24/17, at 1:04 p.m. facility ving a resident expired insulin	,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.	A. BOILDING.		С
00522		00522	B. WING		10/	27/2017
AME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
T ANTH	IONY HEALTH & REF	ARII ITATION	ISS ROAD NOR HONY, MN 554	-		
(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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 24	21545			
	"NovoLog in unope NovoLog FlexPen stored between 2° freeze. Do not use or exposed to temp (98.6°F). After a via syringe has been p temperatures below days, but should no heat or sunlight." Sanofi-aventis Lan	S-032 dated 2006, indicated ened vials, cartridges, and Prefilled syringes should be and 8°C (36° to 46°F). Do not NovoLog if it has been frozen beratures that exceed 37°C al, cartridge, or Prefilled unctured, it may be kept at v 30°C (86°F) for up to 28 bt be exposed to excessive				
	days at room temp or unopened. Medication Adminis policy dated 5/16, i insulin. Check expi	antus could be stored for 28 erature if the vial was opened stration Subcutaneous Insulin nstructed staff, "5. Obtain ration date. If refrigerated, bom temperature 6. Date first use."				
	The facility adminis (DON) or designee and procedures, econgoing monitoring	THOD OF CORRECTION: strator and director of nursing could review facility policies ducate staff and implement ar system to ensure all resident ranscribed and implemented sician orders.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	•			
21565	MN Rule 4658.132 Medications Self A	5 Subp. 4 Administration of dmin	21565			12/6/17
		ninistration. A resident may dications if the comprehensive)			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00522		B. WING		C 10/27/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	•	
	IONY HEALTH & REH	ΙΔΒΙΙ ΙΤΔΤΙΟΝ				
(X4) ID	SUMMARY STA		IONY, MN 5	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLE DATE
21565	Continued From pa	age 25	21565			
	care as required in 4658.0405 indicate	nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	by: Based on observat review, the facility f self-administration	of medications was allowed for 86) only after an assessment		 R186 has had a self administration medications assessment complet care plans updated as needed. A self-administration of medicassessment has been completed 	ed with ations on any	
	Findings include:			other residents wishing to self-adr medications at the bedside.3. Staff will be re-educated on the		
	a.m. and an Ventol open the airway) w	observed on 10/24/17, at 10:16 in inhaler (medication used to as observed on top of the nd available for use.		 for accurate completion of a self-administration of medication for resident that wishes to self-admin medications. 4. Nursing leadership will assess 	ister	
		ved on 10/24/17, at 10:45 a.m. t the inhaler on her nightstand he needed it.		medication administration compet 5 nurses per week until all Nurses been assessed. 5. Nursing leadership will audit t	ency for have	
	indicated she had b	e Sheet on R186's record been admitted 5/28/15, with a ided chronic obstructive		accuracy of the self administration medications assessment with eac quarterly, annual, or significant ch condition MDS. 6. The audits will be reviewed ar	n of h ange of	
	R186's Physician Orders dated 5/29/16, included an order for the Ventolin to be used every four hours as needed for shortness of breath and included, ""may leave at bedside for SAM (self- medication administration)."			 identified concerns will be brough facility QAPI committee for further recommendations. 7. The Director of Nursing remain responsible to ensure residents and assessed for the ability to self-adr 	t to the ins re	
	medication assess	elf-administration of ment dated 9/26/17, indicated the nursing staff administer the		medications.	in notor	

Minnesc	ta Department of He	ealth			APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
			A. BUILDING		С
		00522	B. WING		27/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
ST ANTH	ONY HEALTH & REF		SS ROAD NO		
	1	SIANIH	ONY, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From pa	age 26	21565		
	verified R186 had a	:19 a.m. registered nurse-F an order to leave the bedside, but was not assessed he medication.			
	The director of nur- regarding the proce- resident capability medications. An a identify and assess capability to particip	THOD OF CORRECTION: ses could inservice staff ess for determination of to safely self-administer udit could be conducted to s residents who have the pate in self-administration. This e quality assurance plan.			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-One			
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610		12/6/17
	must store all drug under proper temp	e of drugs. A nursing home s in locked compartments erature controls, and permit rsing personnel to have			
	by: Based on observat review, the facility f residents (R221, R Lantus (a long activit treatment of elevat receive expired me (R57) who received	ent is not met as evidenced ion, interview and document failed to ensure 4 of 20 15, R127, R57) who received ng insulin used for the ed blood sugars) did not edication and 1 of 8 residents d NovoLog (a short acting ment of elevated blood sugars) ired medication.		 The identified expired insulins were removed from the med carts as soon as notified about the concern during the annual survey. R221, R15, R127, and R57 have had a Medication Error Report completed, MD notified, and insulin orders reviewed. Identified staff involved in these medication errors were re-educated on the error as part of the medication error report. 	9

Minnesota Department of Health STATE FORM

0QGF11

If continuation sheet 27 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00522		B. WING		C 10/27/2017	
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
		3700 EOS	S ROAD NO			
	IONY HEALTH & REH	ABILITATION ST ANTH	ONY, MN 5	5421		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
21610	Continued From pa	age 27	21610			
	9/14/17, indicated F received insulin inje had a diagnosis of where blood sugars polyneuropathy (ne diabetes). During medication 10/23/17, at 7:12 p (LPN)-C prepared I of Lantus was date LPN-C entering R2 LPN-C entering R2 LPN-C and had hin the vial. LPN-C ver and he had not bee stated Lantus is on comes out of refrig destroyed on 10/15 R221's October 20 Records revealed F 10/2/17, for Lantus Lantus 22 units from R221's blood sugar milligrams/deciliter range 70-100 mg/d from 10/2/17, to 10 varied from 101mg of time from 10/16 R15's quarterly MD was moderately inc making, received ir week and had a dia During medication	administration observation on .m. licensed practical nurse R221's Lantus 22 unit. The vial d as opened 9/18/17. Prior to 21's room surveyor stopped n check the expiration date on ified the Lantus was expired en aware it was expired. LPN-C ly good for 28 days after it eration, and should have been 5/17. 17 Medication Administration R221 had an order dated 22 units daily. R221 received m 10/2/17 through 10/23/17. rs varied from 83 (mg/dl) -217 mg/dl (normal ll) during the period of time /15/17. R221's blood sugars /dl-207mg/dl during the period		 All other residents with an Insulin have had their insulin expiration dates. Licensed Nurses will be in medication administration and 5. Licensed Nurses have be education on medication administration and and Diabetes through Health Academy to be completed by 6. PharMerica Nurse Consu- conduct a medication administration administration administration administration conduct storage audit on 11/28/17 and 7. All Nurses will complete a storage self competency eact work until the next QAPI meet 12/19/17. Nursing leadership will com medication administration conduct assessments on 5 Nurses per all Nurses have been assess 9. Nursing leadership will com medication storage competent weekly until the next QAPI met 12/19/17. The facility QAPI commit review completed audits and error reports monthly and mar recommendations. See also F333. The Director of Nursing r responsible for compliance w requirement to ensure that ph services are provided to meet of each resident. 	checked for n-serviced on d storage een assigned inistration Care 12/6/17. Iltant will stration and d 11/29/17. a medication h shift they ting omplete mpetency r week until ed. omplete 5 ncy audits eeting tee will medication ke further emains ith this narmaceutical	

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00522	B. WING		C 10/27/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(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 THE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	age 28	21610			
	vial had been date stated Lantus was stated R15 had rec Twenty-eight days R15's October 201 Records revealed 9/26/17, for Lantus Lantus 20 units fro R15 received Lantudays. R15's blood	dl during the period of time				
	R127 was cognitive	S dated 10/5/17, indicated ely intact, received insulin ays a week and had a tes mellitus.				
	at 7:24 p.m. Lantus with a sticker on it 9/17/17, and expira Registered nurse (currently in the hos the hospital on 10/ Lantus vial indicate	cart observation on 10/23/17, s vial for R127 was observed that indicated date open of ation date of 10/15/17. RN)-G stated R127 was spital and had been admitted to 28/17. RN-G verified date on ed it had been opened 9/17/17, was only good for 28 days.				
	Records revealed 10/9/17, for Lantus received Lantus 20	17 Medication Administration R127 had an order dated 20 units daily. R127 had 0 units from 10/11-10/19/17. Intus from an expired vial for prired.				
		report closed 10/25/17, antus vial was opened 9/17/17	,			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION				- (X3) DATE SURVE COMPLETED C - 10/27/201	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		10,	21/2011
	IONY HEALTH & REH	3700 EO	SS ROAD NOF			
JIANII		ABILITATION ST ANTH	IONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	ge 29	21610			
	and should have be	een discarded 10/15/17.				
	R57 was severely of insulin injections set diagnosis of diabete During medication at 9:46 a.m. Lantus with a sticker on it t 9/21/17, LPN-E ver morning. LPN-E sta and for some reaso the Lantus vial was should have been of LPN-E verified R57 medication cart dat should have been of day on 10/18/17. Life received NovoLog	S dated 9/20/17, indicated cognitively impaired received even days a week and had a es mellitus. Cart observation on 10/24/17, invial for R57 was observed hat indicated date open of ified R57 received Lantus that ated she had given the Lantus on had not checked the date opened. LPN-E stated the via disposed of on 10/18/17. Thad a vial of NovoLog in the ed opened 9/21/17 which disposed of at the end of the PN-E stated R57 had not that day. LPN-E stated an that was given would be a				
		10/24/17, at 10:01 a.m. RN-D d insulin would be a				
	Records revealed F for Lantus 20 units Lantus 20 units from R57 received Lantu days after it expired Administration Rec order dated 9/18/17 times a day based	7 Medication Administration R57 had an order dated 8/3/17 daily. R57 had received m 10/1/17, through 10/24/17. Is from an expired vial for six d. R57's October Medication ords revealed R57 had an 7, for Novolog insulin three on blood sugars greater than d received six doses of er 10/18/17.	,			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00522	B. WING			C 10/27/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	ABILITATION	SS ROAD NOF IONY, MN 554				
(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 T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21610	Continued From pa	age 30	21610		·		
		n 10/24/17, at 1:04 p.m. facility iving a resident expired insulin ition error.					
	director of nurses (expected the nurse any vial of insulin a not give the expire Lantus and NovoLo from the time they or when they were	n 10/26/17, at 2:32 p.m. the (DON) stated she would have es to check the date open for and if expired the nurses would d insulin. The DON stated og are only good for 28 days were removed from the fridge opened. The DON stated lin would be a medication					
	insert NDA 20-986, "NovoLog in unoper NovoLog FlexPen stored between 2° freeze. Do not use or exposed to temp (98.6°F). After a vis syringe has been p temperatures below	ministration Novolog drug /S-032 dated 2006, indicated ened vials, cartridges, and Prefilled syringes should be and 8° (36° to 46°F). Do not NovoLog if it has been frozen beratures that exceed 37°C al, cartridge, or Prefilled bunctured, it may be kept at w 30°C (86°F) for up to 28 ot be exposed to excessive					
	8/2015, indicated L	tus medication insert revised antus could be stored for 28 erature if the vial was opened					
	instructed staff, "12 stored in the refrige date on the label for first used. The ope in refrigerator or at	age of Medication dated 5/16, 2. Insulin products should be erator until opened. Note the or insulin vials and pens when ened insulin vial may be stored room temperature 14. nated, discontinued or					

STATE FORM

Minnesc	ota Department of H	ealth			-	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED	
		DENTIFICATION NOMBER.	A. BUILDING			
		00522	B. WING		C 10/27/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ςτ ΔΝΤΗ	ONY HEALTH & REI		SS ROAD NO	-		
	1	SIANIF	IONY, MN 55	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
21610	Continued From pa	age 31	21610			
	cracked, soiled or immediately remov	ations and those that are without secure closures are ved from stock, disposed of dures for medication				
	The director of nur develop, review, an procedures to ensi- vaccination solutio not expired. The d designee could ed the policies and pr nursing (DON) or o	THOD OF CORRECTION: sing (DON) or designee could nd/or revise policies and ure medications including n, are appropriately stored and irector of nursing (DON) or ucate all appropriate staff on ocedures. The director of designee could develop s to ensure ongoing				
	TIME PERIOD FO (21) Days	R CORRECTION: Twenty-one	•			
21665	MN Rule 4658.140	0 Physical Environment	21665		12/6/17	
	functional, comfort environment, allow	ust provide a safe, clean, able, and homelike physical ring the resident to use gs to the extent possible.				
	by: Based on observative review, the facility environment for 10 R40, R26, R14, R4 Findings include:	nent is not met as evidenced tion, interview, and document failed to ensure a sanitary of 11 residents (R271, R110, 45, R267, R191, R34, R45). d 12/3/16, and discharged back	x	 10 out of 10 resident environmental concerns were immediately addressed. Each resident room and resident bathroom in the facility was reviewed for cleanliness. Each resident wheelchair was reviewed for cleanliness and repair. Each resident grab bar was reviewed 		

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00522	B. WING		C 10/27/2017	
AME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		3700 EOS	S ROAD NO			
IANIF	IONY HEALTH & REH	ABILITATION ST ANTH	ONY, MN 5	5421		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	age 32	21665			
	to hospital by 911 c The admission diag disease, dementia, food safely) with fe to communicate, hi kidney cancer with Foley catheter. R27 assistance with bed use; was totally dep and eating (tube fe spouse complained seat, and unclean n R110 had an annua assessment on 8/1 impairment, and die extensive assistand transfers and toilet R110's call light wa the light. R110's roo length of the wall h wheelchair armrest covering which mad R40 quarterly MDS indicated R40 was moderately severe independent with s 10/24/17, at 9:10 a were tattered, with uncleanable surfac cushion remained of detached from the would stand up, rea with multiple bevera the way to the call I on 10/24/17, registo	on 4/3/17 per the Face Sheet. gnoses include Parkinson's dysphagia (inability to swallow eding tube for nutrition, unable istory of heart bypass and urine retention and suprapubic 71 required extensive d mobility, transfers, and toilet bendent on staff for dressing eding). On 4/3/17, R271's d of feces and urine on toilet		to ensure material is intact. 5. Each resident call light audited for function and pla 6. Each resident room has checked for extra cable box 7. Housekeeping policies and all Housekeeping staff re-educated on proper clea techniques. 8. The housekeeping and department will conduct em audits of items #2-#5 weekl facility QAPI meeting on 12 9. The facility QAPI comm review completed audit rest further recommendations. 10. The Executive Director responsible for compliance requirement, to ensure that provided a safe, functional, comfortable environment.	cement. s been ses. were reviewed were ning maintenance <i>v</i> ironmental y until the next /19/2017. ittee will ults and make remains with this residents are	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
						с	
		00522	B. WING		10/	10/27/2017	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
T ANTH	IONY HEALTH & REF		SS ROAD NOF IONY, MN 554				
(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	
21665	Continued From pa	age 33	21665				
	 wheelchair arm res white padding were exported padding were exported and appeared to be substance. During a tour on 10 maintenance direct director said surface cleaned. R26's annual assets indicated R27 had and needed extensions bed mobility, transfat 4:19 p.m. R26's mattress. R26 was she can use it to ge p.m. licensed pract 	faces of both the manual sts were cracked and areas of e clearly visible. More areas of used on front of both armrests e soiled with a light brown 0/26/17, at 1:39 p.m. the acting tor and the housekeeping tor and the housekeeping ce of the armrests could not be ssment dated 9/22/17, severely impaired cognition, sive assistance of two staff for fers and toilet use. On10/23/17 call light was trapped under unable to reach it. R26 stated et staff. On 10/23/17, at 4:19 tical nurse (LPN)-C came into I and put the call light close to					
	On 10/24/17, at 9:5 was not kept clean the sink, but it gets sink when it's dirty There was missing heater. R45's quarterly MD indicated R45 was	9/25/17, per the Face Sheet. 50 a.m. R14 stated the sink in the bathroom. Staff clean dirty fast and "I cannot use the because of my colostomy." grout around the base of OS review dated 8/25/17, cognitively intact, needed					
	transfers and toilet the grab bars on th and were no longer R267 was admitted	ce of two staff for bed mobility, use. On 10/23/17, at 7:47 p.m le bed had foam peeling off r a cleanable surface. d to the facility on 10/11/17, per n 10/24/2017, at 11:07 a.m.					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00522	B. WING		C 10/27/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REF		SS ROAD NOF IONY, MN 554			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21665	Continued From pa	age 34	21665			
	clean, "like today I	times the bathroom was not walked in there and it wasn't nd housekeeping came had to it."				
	9/12/17, indicated I with minimal depre assistance of two s and toilet use. On	on MDS assessment dated R191 was cognitively intact ssion, and needed extensive staff for bed mobility, transfers 10/24/17, at 1:08 p.m. there ed brown stain on grout of toile	t			
	indicated R34 was depression, and ne	iew MDS dated 9/29/17, cognitively intact with minimal eeded limited assistance of one ty, transfers and toilet use.	9			
	approximately 7:00 observed to contain by two cables appr wall, about two feet	oserved on 10/23/17, at p.m. R34's room was n a cable internet box hanging oximately six inches out of the t to the right of the head of n the headboard and the				
	observation and sa and it had been the man had given her	ed at the time of the id some man had left it there ere for months. R34 said the a television remote. R34 ote from her bedside stand, stil	1			
	from the maintenar	nmunications dated 5/12/17, nce director to the facility ated cable instillation was to 12, 2017.				
	R45's room was ob	oserved on 10/23/17, at				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					- c	
		00522	B. WING		10/27/2017	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21665	Continued From pa	age 35	21665			
	grab bar was obser	p.m., R45's bed right side rved to have foam on the top o ped, with approximately three	f			
	maintenance direct	0/26/17, at 1:39 p.m. the acting for and the housekeeping se of the grab bar could not be				
	ceiling vents near t were noted to have surfaces of all of th	proximately 7:00 p.m., the he fire door on 2 North unit a fine gray substance on the e grates in each vent. The as noted on the ceiling tiles y vents.				
	housekeeping direct staff should have c housekeeping direct housekeeping staff maintenance depar arms, the damaged hanging from the w director said the ho resident areas as p schedule and were maintenance depar identified and leave	on 10/25/17, at 2:18 p.m., the ctor said the housekeeping leaned the ceiling vents. The ctor said a member of the should have notified the rtment about the wheelchair d side rail and the cable box vall. The housekeeping busekeeping staff inspected wart of their daily cleaning instructed to call the rtment if a concern was a voicemail message on the ection line to initiate order.				
	the acting director of checked the Mainte compiled a list of w orders were stored	on 10/25/17, at 10:53 a.m., of maintenance said she enance Connect line daily and ork orders. She said the work in this list until completed. A was provided, with work orders				

Minnesc	ta Department of He	alth				APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00522	B. WING	B. WING		C 27/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	IARII ITATION	SS ROAD NOF			
		SIANIF	IONY, MN 554			0.75
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21665	Continued From pa	ige 36	21665			
	dating back three n	nonths.				
	10/26/17, at 9:31 a maintenance depar orders. After review orders, the facility a surprised by the nu	with the administrator on .m., she said she expected the treat to prioritize the work ving the current list of work administrator said she was mber of unfinished work e questioned about how the prioritized.	•			
	policy and Procedu instructed any emp	Vork Order/Repair Requisition re last reviewed on 8/09 loyee to call and report s and to request service.				
	The DON or desigr conduct periodic at	THOD OF CORRECTION: nee could educate staff and udits of areas residents a home like environment is ent possible.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			12/6/17
	residents shall, at a are legal rights for stay at the facility o treatment and main that these are deso written statement o responsibilities set case of patients ad as defined in section	tion about rights. Patients and admission, be told that there their protection during their r throughout their course of atenance in the community and ribed in an accompanying f the applicable rights and forth in this section. In the mitted to residential programs on 253C.01, the written o describe the right of a	1			

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING	:		
		00522	B. WING		C 10/27/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH	IARII ITATION	S ROAD NO			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLE ⁻ DATE
21800	Continued From pa	age 37	21800			
	provided in section shall list the names individuals and org advocacy and lega residential program accommodations s communication imp speak a language facility policies, insp local health authori the written statement to patients, residen chosen representa to the administrato person, consistent	d or older to request release as 253B.04, subdivision 2, and anizations that provide I services for patients in ans. Reasonable shall be made for those with pairments and those who other than English. Current pection findings of state and ities, and further explanation of ent of rights shall be available ths, their guardians or their tives upon reasonable request r or other designated staff with chapter 13, the Data section 626.557, relating to				
	by: Based on interview facility failed to pro discontinuation of s (R7, R8) who rema Medicare covered Findings include: R8 received a Noti dated 1/24/17, for a 1/26/17. R8 remain Medicare days rem determination of co R8 received a Noti	ce of Medicare Non-Coverage a coverage end date of ned in the facility, with 79 naining but did not receive a		 R7 remains in the facility. been discharged, The appropriate Notice of Non-Coverage forms have be The facility has developed Notice procedure. The facility MDS coordina Social Workers have been in- the Medicare Notice procedure Facility leadership will aud coverage notice per week for notice until the next facility QA on 12/19/17. The facility QA&A commit review completed audit results further recommendations. 	Medicare en initiated. I a Medicare tors and serviced on e. lit 1 end of appropriate .PI meeting tee will	

STATE FORM

0QGF11

If continuation sheet 38 of 62

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	COM	E SURVEY PLETED
		00522	B. WING		C 10/27/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NO ONY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21800	Continued From pa	ige 38	21800			
	 Medicare days remaining but did not receive a determination of continued stay. Licensed social worker (LSW)-A stated R8 was given notice of Medicare Non-Coverage on 7/21/17, but verified there was no documentation of notice of Medicare Non-Coverage. R7 received a Notice of Medicare Non-Coverage dated 10/5/17, for a coverage end date of 10/7/17. R7 remained in the facility, with 59 Medicare days remaining but did not receive a determination of continued stay. 			responsible for compliance with requirement, to ensure each re receives notice of changes in c	sident	
	dated 10/27/17, for 10/27/17. R7 remai	ce of Medicare Non-Coverage a coverage end date of ined in the facility, with 52 aining but did not receive a intinued stay.				
	LSW-A stated the M Coordinator provide Medicare Non-Cove that the MDS Coord a form to issue to re make sure they kno LSW-A verified they CMS 10123) and the	on 10/27/17, at 7:45 a.m., Minimum Data Set (MDS) ed education on the Notice of erage. LSW-A further indicated dinator gave the social workers esidents and/or families and by they have a right to appeal. y only gave one form (Form ney also gave a denial letter plicable to the resident.				
	The administrator of review, and/or revise ensure staff are eduliability notices to pro- Medicare services, are communicated The administrator of appropriate staff or	THOD OF CORRECTION: or designee could develop, se policies and procedures to ucated on the appropriate rovide residents at the end of and to ensure resident rights appropriately and acted upon. or designee could educate all the policies and procedures monitoring systems to ensure				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DATE SURVEY	
					С	
		00522			10/27/2017	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S ROAD NO	STATE, ZIP CODE		
ST ANTH	ONY HEALTH & REF		ONY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE	
21800	Continued From pa	age 39	21800			
	ongoing complianc	e.				
	TIME PERIOD FO (21) Days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC F	.651 Subd. 5 Patients & ac.Bill of Rights	21805		12/6/17	
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a				
	by: Based on observation review, the facility of dignified manner for required assistance Findings include: During observation nursing assistant (I mechanical lift in the large wet spots on pants. NA-B said, " resident's name], I most." Registered present added, "The "I would swear these and take water pills these statements in R150's quarterly M	ent is not met as evidenced ion, interview and document failed to provide care in a or 1 of 5 residents (R150) who e with activities of daily living. on 10/25/17, at 1:38 p.m. NA)-B stood R150 utilizing the ne bathroom. There were two the back of the resident's Between her and [another don't know who wets the nurse (RN)-C who was also ney wet a lot." NA-B remarked, se two drank 50 gallons a day s." NA-B and RN-C made in front of R150. inimum Data Set (MDS) dated, 150 had dementia and		 The identified resident R150 has had her care plans and NAR assignment sheets reviewed and updated as needed to include providing for privacy and dignit 2. The responsible staff were re-education on privacy and dignity as soon as notified of the concern during the annual surver 3. Staff will be re-trained on providing for resident privacy and dignity using spect examples cited in the CMS-2567. Nursing leadership will assess private and dignity competency on 6 staff members a week until all nursing staff have been assessed. Nursing leadership will also look at potential privacy and dignity issues whi completing various scheduled audits su as med pass audits, NAR direct care audits, toileting, etc. The Director of Nursing will review th completed audits and bring any identified 	ed hity. ed ed y. or fic cy le uch	

If continuation sheet 40 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		SURVEY
ID PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:		PLETED
		00522	B. WING			C 2 7/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
Γ ΑΝΤΗ	ONY HEALTH & REH	IARII ITATION	SS ROAD NO			
		ST ANTH	IONY, MN 5			
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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLE DATE
21805	Continued From pa	age 40	21805			
	noted R150 was ar and R150 was freq and bowel. During interview or	the MDS. The MDS further extensive assist with all ADLs uently incontinent of bladder 10/25/17, at 2:07 p.m. NA-B statements in front of R150 s nervous.	3	committee for review and furth recommendations. 7. The Director of Nursing rem responsible for compliance wit requirement to ensure residen to personal privacy and confid 8. See also F164	ains h this ts the right	
	stated she thought information to expla changed every two	10/25/17, at 2:22 p.m. RN-C NA-B was trying to provide ain that all residents were hours. RN-C confirmed NA-B to explain that until they were 50's care.				
	The DON or design dignity and respect then interview resid	THOD OF CORRECTION: nee could educate staff on . The DON or designee could lents routinely to ensure dignity and respect are being				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			12/6/17
	residents shall have medical and person needs. Appropriate care designed to en highest level of phy This right is limited	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve thei vsical and mental functioning. where the service is not blic or private resources.				

		IDENTIFICATION NUMBER:		:		
			B. WING		C	
		00522			10/2	7/2017
T ANTHC	ROVIDER OR SUPPLIER		DRESS, CITY,			
	ONY HEALTH & REH		ONY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLE DATE
21810 (Continued From pa	ge 41	21810			
H H H H H H H H H H H H H H H H H H H	by: Based on observati review, the facility fa- easily accessible in assistance for 1 of 6 have a call light not Findings include: R26's care plan effe- indicated R26 had i staff to keep the ca R26's annual Minim 9/22/17, indicated F impairment and req from two staff mem (ADLs) that involver identified R26 for be On 10/23/17, at 4:1 their room, seated i the end of the bed f button placed unde unable to reach the did use the call ligh licensed practical n light was not within reposition the call li the reach. During an interview director of nursing s checked every time whoever walked in The facility policy tit	ent is not met as evidenced on, interview, and document ailed to ensure a call light was order to summon staff 5 residents (R26) observed to in within reach. ective 1/26/15, to present, mpaired vision and instructed Il light with-in reach. num Data Set (MDS) dated R26 had moderate cognitive juired extensive assistance bers for activities of daily living d mobility. The MDS also eing at risk for falls. 9 p.m. R26 was observed in in a manual wheelchair, near facing the wall. R26's call light r the mattress and R26 was call light. R26 indicated she t to get staff. At 4:19 p.m. urse (LPN)-B verified the call R26's reach and proceeded to ght for R26's so it was within on 10/26/17, at 9:00 a.m. the said call lights should be there was staff in the room; that room should be checking.		 Resident R28 care plans and assignment sheets have been re- and updated as needed. Staff will be re-trained on pro resident accommodation of need specific survey examples cited in 2567. Facility leadership will complet light placement audits 2x/week up next QAPI meeting 12/19/17. The Director of Nursing will re completed audits and bring any ic concerns to the facility QAPI com for review and further recomment 5. The Executive Director rema responsible for compliance with t requirement to ensure residents a provided services with reasonable accommodation of individual nee 	viewed viding for s, using the ete call ntil the eview the dentified mittee dations. ins his are e	
	to					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ATE SURVEY OMPLETED	
			B. WING		С	
		00522			0/27/2017	
		3700 EQ	SS ROAD NO	STATE, ZIP CODE PRTHEAST		
SIANIF	IONY HEALTH & REF	ABILITATION ST ANTH	IONY, MN 55	421		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE	
21810	Continued From pa	age 42	21810			
		light with reach. The protocol nust always be placed in the nt."				
	The director of nur develop, review, ar procedures to ensu resident reach. The educate all approp procedures. The D	THOD OF CORRECTION: sing (DON) or designee could nd/or revise policies and ure call lights are kept within e DON or designee could riate staff on the policies and ON or designee could develop s to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	•			
21855	MN St. Statute 144 Residents of HC F	.651 Subd. 15 Patients & ac.Bill of Rights	21855		12/6/17	
	residents shall hav and privacy as it re personal care prog consultation, exam confidential and sh Privacy shall be res bathing, and other	nent privacy. Patients and e the right to respectfulness lates to their medical and ram. Case discussion, ination, and treatment are all be conducted discreetly. spected during toileting, activities of personal hygiene, for patient or resident safety or				
	by: Based on observat review, the facility t resident's personal of 5 residents (R83	ent is not met as evidenced ion, interview and document failed to maintain privacy of a care related information for 1 reviewed who was aff for activities of daily living		 The identified resident R83 has had her care plans and NAR assignment sheets reviewed and updated as needer to include providing for privacy and dign 2. The responsible staff were 	d	

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	LETED
		00522	B. WING		10/2	7/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NO IONY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21855	Continued From pa	age 43	21855			
	(ADLs).			re-educated on privacy an		
	nursing assistant (I mechanical lift in the large wet spots on pants. NA-B said, " know who wets the (RN)-C who was al- lot." NA-B remarked drank 50 gallons a NA-B and RN-C ma- of R150 about R83 R150's quarterly M 8/2/17, indicated R Alzheimer's diseas cognitive portion of noted R150 was ar and R150 was freq and bowel. R83's quarterly MD R83 had dementia the cognitive portio further indicated R8 with all ADLs and F of bladder and bow During interview on verified making the incontinence in from nervous. During interview on	inimum Data Set (MDS) dated 150 had dementia and e, and could not complete the the MDS. The MDS further n extensive assist with all ADLs uently incontinent of bladder PS dated 9/20/17, indicated and was unable to complete n of the MDS. The MDS 33 required extensive assist R83 was frequently incontinent rel. 10/25/17, at 2:07 p.m. NA-B statement about R83's nt of R150 and stated she was	,	 soon as notified of the corannual survey. Staff will be re-trained resident privacy and dignit examples cited in the CMS Nursing leadership will and dignity competency or members a week until all thave been assessed. Nursing leadership will potential privacy and dignit completing various schedulas med pass audits, NAR audits, toileting, etc. The Director of Nursin completed audits and brin privacy concerns to the factor memorations. The Director of Nursin responsible for compliance requirement to ensure rest to personal privacy and construction. See also F241 	l on providing for ty using specific S-2567. Il assess privacy n 6 staff nursing staff Il also look at ity issues while uled audits such direct care ng will review the g any identified cility QAPI further ng remains e with this idents the right	
	information to expla	NA-B was trying to provide ain that all residents were hours and R83 was changed				

If continuation sheet 44 of 62

	ta Department of He					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00522	B. WING			C 27/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REF		SS ROAD NOF IONY, MN 554			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLETE DATE
21855	Continued From pa	age 44	21855			
		confirmed NA-B should have nat until they were done are.				
	stated staff "should	n 10/25/17, at 2:49 p.m. RN-D I be focused on the resident ith and not talk about any othe	r			
	director of nursing	n 10/26/17, at 2:32 p.m. the verified the staff should not 3 while providing care to				
	included: "Staff will information in locat conversations may	dentiality policy dated 6/26/12, not discuss any client ions where these be overheard by unauthorized ther clients or visitors."				
	nursing (DON) or d medical director to procedures related and then educate s or designee could a	of Correction: The director of lesignee could work with the update policies and d to resident's right to privacy staff of these rights. The DON also perform audits of resident the this right had been				
	Time Period for Co days.	rrection: Twenty-one (21)				
21995	MN St. Statute 626 Maltreatment of Vu	5.557 Subd. 4a Reporting - Inerable Adults	21995			12/6/17
	(a) Each facility sh ongoing written pre	I reporting of maltreatment. Iall establish and enforce an ocedure in compliance with g rules to ensure that all cases				

Minnesota Department of Health STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	<u>، د</u>	ATE SURVEY OMPLETED
		00522	B. WING		0/27/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
T ANTH	IONY HEALTH & REF		SS ROAD NO ONY, MN 5		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE DATE
21995	Continued From pa	age 45	21995		
	facility has an intermandated reporter requirements of thi internally. However responsible for com- reporting requirements This MN Requirements Based on interviewer facility failed to oper prevention policy for alleged verbal abuser made by staff. In and ensure a bruise of resident's thigh water (SA) in a timely material (SA) in	ent is not met as evidenced and document review, the prationalize their abuse or 1 of 1 resident (R31), who se with derogatory comments ddition, the facility failed to unknown origin located on a s reported to the State agency unner for 1 of 1 resident to the facility on 3/24/17. The resident's record indicated g: spinal stenosis of neck, ure of first lumbar vertebra, diabetes, and history of with R31 on 10/24/17, at 1:18 e had "complained to a nurse ant (NA)-[G] emotionally hurt d her the devil about 20 times." J said nobody out here likes e the devil." R31 stated she cident to the nurse who was		 The allegation of abuse by R31 has been reported and investigated. The bruise for R150 has been investigated. The facility Vulnerable Adult Abuse Prevention policy and procedure has be reviewed and remains appropriate. The Administrator and DON attended VAA education at Care Providers joint training on 11/7/17. Staff have been re-educated on the facility Vulnerable Adult Abuse Prevention policy and program. The IDT will review each incident to determine if reportable and appropriate preventative measures are put in place. The facility QAPI committee will review all incidents monthly. See also F225. The Executive Director remains responsible for compliance with this requirement, to ensure that all alleged violations involving mistreatment, negle or abuse, including injuries of unknown source are reported immediately 	on W
		ted 7/26/17, directed staff to procedures prior to performing,			

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00522	B. WING			C 0/27/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	lge 46	21995		,		
	offer validation of fe chart "prefers male prevention, monitor accusations of abu report all signs and neglect. Staff to ass to prevent bumping residents. The Cog care plan indicated assessed, care pla deemed appropriat (IDT). The undated indicated R31 prefe On 9/27/17, R31's of (MDS) assessment cognitively intact, re staff with bed mobi incontinence cares pain. The assessm no behavioral issue psychoactive medic Registered nurse (I 10/25/17, at 2:23 p received a voicema been working on th	eelings, social service note in care givers", abuse for all signs and symptoms, se or neglect. Investigate and symptoms of abuse or sist resident out of dining room into or altercations with other nition/Behavior/Psychosocial behavioral needs would be nned and addressed as e by the interdisciplinary team , Group 2 assignment sheet erred male caregivers. quarterly Minimum Data Set t indicated the resident was equired extensive assist of one lity, transfers, toilet use, , and also experienced some ent further indicated R31 had as and was not receiving any					
	devil. RN-H said sl the next day. RN-H incident had ever h not to take care of	he had followed up with R31 stated NA-G had denied the appened, but was instructed R31 again. RN-H said R31 with not having NA-G take					
	documented on a g "did not call it emot reported to the adm (DON), or the SA. I had received anoth	prievance form. RN-H said R31 ional abuse" so it was not ninistrator, director of nursing RN-H further stated that she er complaint about NA-G from ner family, whose roommate					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00522	B. WING		10/)/27/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST ANTH	IONY HEALTH & REH	IARII ITATION	SS ROAD NOF IONY, MN 554				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21995	Continued From pa	age 47	21995				
	was being lifted by NA-G. The family member who stated NA-G had to be stopped during the lift and told she needed help. Then notified RN-H that she could not care for her mother. RN-H stated she had very experienced aides who knew her residents well and NA-G "can't be on my unit." RN-H further remarked, at that point NA-G was transferred to another unit with some additional platinum service training which was scheduled on 11/1/7.						
	medical record by t that indicated: on 1 nurse that she did n to her to care for he nurse "I don't like h nurse asked NA if s stated "No." The nu resident was satisfi 10/25/17, further in manager followed u concern, notified re assigned to anothe satisfied. The resid statements of feelin Documentation cor resident stated to N of Health) surveyor abused by a NA wh administrator was r and was on-going N	e was documented in R31's the director of nursing (DON) 0/22/17, R31 complained to not want the new NA assigned er any longer. R31 stated to er, she called me evil." The she called resident evil and NA urse re-assigned NA and ed. The documentation on dicated on 10/23/17, the nurse up with resident on her sident that NA would be r floor and resident was ent did not make any ng verbal abuse occurred. tinued on 10/25/17, noted the <i>IDH</i> (Minnesota Department that she had been verbally no called her evil. The notified, investigation initiated NA has already been assigned unit with extra orientation and will no longer care for the					
	interviewed. The D R31 didn't say she	27 p.m. the DON was OON said "I think at the time was upset about it, but had e that person such as, 'she's					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00522	B. WING			C 27/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		S ROAD NOF ONY, MN 554			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
21995	Continued From pa	age 48	21995			
	people at all." The l expectation of staff was made, staff was and DON immediat complaint/ grievand thought R31 just die nursing assistant. I didn't think it was a situation. The DON to the resident right feel comfortable if t another part of the indicated would be that calling resident and a resident did n verbally abused for The facility failed to verbal/emotional at	t like her.' R31 doesn't like new DON further stated her was if an allegation of abuse buld inform the administrator tely. She added that since a ce form had been used, she'd d not like that particular n addition, the DON said she n emotionally distraught also stated RN-I had spoken t away and asked if she would they moved that staff to building which R31 had ok. However, the DON verified t's names was verbal abuse, not have to say they were it to be reported as abuse.				
	R150's quarterly M R150 had dementia could not complete MDS. The MDS fur extensive assist wit (ADLs) including tra An Occurrence Rep that on 10/3/17, at cares R150 had a b which measured 10 the occurrence rep explain how she su nurse documented	DS dated, 8/2/17, indicated a and Alzheimer's disease, and the cognitive portion of the ther noted R150 was an th all activities of daily living ansfers and ambulation. port closed 10/6/17, revealed 7:30 a.m. during morning pruise on her right inner thigh 0 centimeter (cm) by 9 cm. Per ort, R150 was unable to istained it. Licensed practical , "Res [Resident] must have				
	during transfer. Ma	o the Broda chair arm rest Itreatment and abuse is not nce Report wound description				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	or connection	IDENTITION TON NOMBER.	A. BUILDING:	·····	-		
		00522	B. WING			C // 27/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	IONY HEALTH & REH	IARII ITATION	SS ROAD NOF				
		SIANIF	IONY, MN 554				
(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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	age 49	21995				
21995	R150 sometimes re transfers due to be indicated in the Co dated 10/5/17, at 1 bruise incident. The indicated R150 had cares, striking out a attempt to self-tran assistance to trans indicated resident b pattern and bruise Broda chair, and bu happened when R ⁻ into the chair. Inter "Staff will cont [con assisting this reside techniques to have The Occurrence Re	as blackened. Report indicated equired assist of two with haviors. The occurrence report 1:54 a.m. the IDT reviewed e conclusion section of report d a history of being resistive to at staff during cares, would sfer, R150 required staff fer. Occurrence Report oruise was in a non-hand grasp lined up with the armrest of the ruise was likely to have 150 was attempting to sit down vention implemented was tinue] to use caution when ent and use Montessori e res cooperative with cares." eport did not indicate ty administrator or director of	t				
	10/24/17, did not re administrator of the	s notes from 9/3/17, through eveal notification of the e bruise. Review of progress ate any instance of R150 sitting nair.	3				
	Documentation Re R150 was very anx cares. R150 was m	Palliative Care Facility Visit cord dated 10/16/17, revealed kious grabbing and upset with nore difficult to redirect with ding bruise on right inner thigh					
	R150 required assi transfers from 8/8/ plan was updated. 8/23/17, instructed	rinted 10/26/17, indicated ist of one staff member for 17 until 10/24/17, when care The intervention dated staff to monitor R150 closely n resident attempted to					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPL	
		00522			10/	27/2017
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
T ANTH	ONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE
IAG			IAG	DEFICIENC		
21995	Continued From pa	age 50	21995			
		at staff would intervene when ent to sit on correct seating as				
	stated R150 would getting dressed sin nervous about rollir R150 would hit staf declined in ability to	10/25/17, at 2:07 p.m. NA-B become aggressive when ce her fall and was very ng over in bed or stand up and if. NA-B stated R150 had o walk. NA-B stated R150 had the arm of the Broda chair rred her.				
	DON stated whene nurse would chart to report. DON stated what happened and happened or there staff will call the ad could report it. The reported it would us meeting the next da with a conclusion a Regarding R150's is stated R150 was un but R150 had a his aggressive during of have bumped her lo stated 10/5/17. DO them the next morr 10/5".DON verified 10/5/17. DON verified thigh is in a suspici Occurrence Report	a 10/26/17, at 12:01 p.m. the ver there was an incident the the incident and start a risk if the resident cannot say d the staff do not know what is an allegation of abuse the ministrator right away, so we DON said if something is not sually be discussed at the IDT ay and the IDT would come up nd put interventions in place. Incident of 10/3/17, DON nable to state what happened tory of being resistive and cares. DON stated R150 must eg during a transfer. When T review the bruise The DON N said, "We always talk about hing, but [R150] wasn't until nurse manager did the IDT on ied that a bruise in the inner ous area. DON stated the torn colusion section was the tion. DON was unable to state				
		10/26/17, at 1:16 p.m. RN-D				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00522	B. WING		C 10/27	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REF	IARII ITATION	SS ROAD NOF			
(X4) ID	SUMMABY ST			PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
21995	Continued From pa	age 51	21995			
	have done the inve- wrote it on 10/5/17 tell you. If I looked investigated it, it we stand up."	work on 10/3/17, but "I might estigation the following day but ." RN-D said, "I honestly can't at it Wednesday and ould have been 9:30 a.m. after n 10/26/17, at 2:54 p.m. d if a bruise of unknown origin				
	was reportable if a what happened, it could not figure ou	resident could not tell you was a suspicious area and we t what happened. The unable to say when she was				
	approved 11/28/16 will immediately re " Administrator/F " Other Officials " State Survey a following state prot The Policy defines	Executive Director in accordance with State Law and Certification agency				
	punishment with re mental anguish. At deprivation by an ir of goods or service or maintain physica well-being. Instanc	esulting physical harm, pain or buse also includes the ndividual, including a caretaker es that are necessary to attain al, mental, and psychosocial es of abuse if all residents, mental or physical condition,				
	cause physical har includes verbal abu abuse and mental facilitated or enable technology. Willful, abuse, means the	m, pain or mental anguish. It use, sexual abuse, physical abuse including abuse e through the use of , as used in this definition of individual must have acted				
nnesota D	intended to inflict in	at the individual must have njury or harm. nt means inappropriate				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			С
		00522	B. WING		10/	27/2017
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
T ANTH	ONY HEALTH & REF	ARII ITATION	SS ROAD NOR IONY, MN 554			
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 52	21995			
	5. Verbal Abus written or gestured disparaging and or their families, or regardless of their disability. 7. Physical Abu hitting, slapping, pi includes controlling punishment. 9. Neglect is th employees or servi and services to a re avoid physical harr emotional distress. implement their Ab policy when allegat	tation of a resident. e means the use of oral, language that willfully includes derogatory terms to residents within their hearing distance age, ability to comprehend, or use includes, but not limited to nching and kicking. It also g behavior through corporal he failure of the facility, it's ice providers to provide goods esident that are necessary to n, pain, mental anguish, or The facility failed to use, Neglect and Exploitation ions of verbal abuse, or n origin were identified.				
	The administrator, designee(s) could in necessary the policy the internal process process of abuse of administrator, DON designee(s) could in appropriate staff or procedures. The ad services or designed all reports of abuse investigated.	THOD FOR CORRECTION: DON, social services or review and revise as sies and procedures regarding s of reporting/investigating the or maltreatment. The I, social services or provide training for all n these policies and dministrator, DON, social ee(s) could monitor to assure a are being reported and R CORRECTION: Fourteen				
22000	(14) days. MN St. Statute 620	6.557 Subd. 14 (a)-(c)	22000			12/6/17
		atment of Vulnerable Adults				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/27/201	
		00522	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		S ROAD NOF ONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
22000	Continued From pa	ge 53	22000			
	facility, except hom personal care atten- establish and enfor- prevention plan. The assessment of the environment, and it factors which may ear and a statement of to minimize the risk comply with any rul- promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or reac The plan shall conta assessment of: (1) abuse by other indiv vulnerable adults; (i) other vulnerable ad specific measures to risk of abuse to that adults. For the purp term "abuse" includ (c) If the facility, of and personal care as knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk the reasonably be expect facility and persons unsupervised. Und	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. including a home health care al care attendant services elop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00522	B. WING		C 10/2	; 7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		3700 EOS	S ROAD NO			
SIANIF	IONY HEALTH & REH	ABILITATION ST ANTH	ONY, MN 5	5421		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLET DATE
22000	Continued From pa	age 54	22000			
	such information fr authority or through another facility, and	rsical aggression if it receives om a law enforcement n a medical record prepared by other health care provider, or g assessments of the				
	by: Based on interview facility failed to ope prevention policy for alleged that staff ve called her evil. In a ensure a bruise of to the State Agency of 1 resident (R150 inner thigh. Findings include:	ent is not met as evidenced and document review, the erationalize their abuse or 1 of 1 resident (R31) who erbally abused her when they ddition, the facility failed to unknown origin was reported y (SA) in a timely manner for 1 b) who had a bruise on the		 The allegation of abuse by been reported and investigated. bruise for R150 has been invest The facility Vulnerable Adult Prevention policy and procedure reviewed and remains appropria The Administrator and DON VAA education at Care Provider training on 11/7/17. Staff have been re-educate facility Vulnerable Adult Abuse F policy and program. The IDT will review each income the second second	The igated. Abuse has been ate. attended s joint d on the Prevention	
	approved 11/28/16 will immediately rep " Administrator/E " Other Officials " State Survey a following state prot The Policy defines injury, unreasonabl punishment with re mental anguish. At deprivation by an ir of goods or service or maintain physica	Executive Director in accordance with State Law nd Certification agency		 The IDT will review each ind determine if reportable and app preventative measures are put if The facility QAPI committee review all incidents monthly. See also F226. The Executive Director rem responsible for compliance with requirement, to ensure that all a violations involving mistreatmen or abuse, including injuries of un source are reported immediatel 	ropriate n place. e will ains this illeged t, neglect, nknown	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	or connection		A. BUILDING:			
		00522	B. WING			C 27/2017
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		3700 FO	SS ROAD NOF	RTHEAST		
T ANTH	ONY HEALTH & REI	HABILITATION ST ANTH	IONY, MN 554	121		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLE DATE
				DEFICIENC	Y)	
22000	Continued From pa	age 55	22000			
	irrespective of any	mental or physical condition,				
	cause physical har	m, pain or mental anguish. It				
	includes verbal ab	use, sexual abuse, physical				
		abuse including abuse				
		e through the use of				
	technology. Willful, as used in this definition of					
	·	individual must have acted				
		at the individual must have				
	intended to inflict in					
		nt means inappropriate				
		itation of a resident.				
		e means the use of oral,				
	disparaging and	l language that willfully includes derogatory terms to residents				
		within their hearing distance	>			
		age, ability to comprehend, or				
	disability.	age, ability to comprehend, or				
		use includes, but not limited to				
		inching and kicking. It also				
		g behavior through corporal				
	punishment.	g senarier in eagin corporat				
		ne failure of the facility, it's				
		ice providers to provide goods				
	and services to a r	esident that are necessary to				
		n, pain, mental anguish, or				
		. The facility failed to				
		use, Neglect and Exploitation				
		tions of verbal abuse, or				
	bruises of unknow	n origin were identified.				
	During an interviev	v with R31 on 10/24/17, at 1:18				
		he had "complained to a nurse				
		ant (NA)-[G] emotionally hurt				
		ed her the devil about 20 times.	"			
] said nobody out here likes				
		e the devil." R31 stated she				
		ncident to the nurse who was				
	working that night.					
	R31 was admitted	to the facility on 3/24/17. The				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED C	
		00522	D. WING		10/	27/2017
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	THE APPROPRIATE	COMPLET DATE
				DEFICIENC	SY)	
22000	Continued From pa	age 56	22000			
	diagnoses including compression fractu	esident's record indicated g: spinal stenosis of neck, ire of first lumbar vertebra, diabetes, and history of				
	explain cares and p offer validation of fe chart "prefers male prevention, monitor accusations of abu report all signs and neglect. Staff to ass to prevent bumping residents. The Cog care plan indicated assessed, care pla deemed appropriat (IDT). The undated indicated R31 prefe	ted 7/26/17, directed staff to procedures prior to performing eelings, social service note in a care givers", abuse r for all signs and symptoms, se or neglect. Investigate and symptoms of abuse or sist resident out of dining room g into or altercations with other inition/Behavior/Psychosocial behavioral needs would be nned and addressed as e by the interdisciplinary team l, Group 2 assignment sheet erred male caregivers.	1			
	(MDS) assessment cognitively intact, re staff with bed mobi incontinence cares pain. The assessm	quarterly Minimum Data Set t indicated the resident was equired extensive assist of one lity, transfers, toilet use, , and also experienced some ent further indicated R31 had as and was not receiving any cations.				
	10/25/17, at 2:23 p received a voicema been working on th regarding R31's co devil. RN-H said sl the next day. RN-H incident had ever h	RN)-H was interviewed on .m. and stated she had ail from the nurse who had e evening of 10/22/17, mplaint of being called the he had followed up with R31 stated NA-G had denied the appened, but was instructed R31 again. RN-H said R31				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED
		00522	B. WING		10/	27/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	ige 57	22000			
	care of her, so the documented on a g "did not call it emot reported to the adm (DON), or the SA. F had received anoth a daughter of anoth was being lifted by who stated NA-G h and told she neede that she could not of stated she had very her residents well a unit." RN-H further was transferred to a additional platinum scheduled on 11/1/	rievance form. RN-H said R31 ional abuse" so it was not ninistrator, director of nursing RN-H further stated that she er complaint about NA-G from her family, whose roommate NA-G. The family member ad to be stopped during the lift d help. Then notified RN-H care for her mother. RN-H y experienced aides who knew and NA-G "can't be on my remarked, at that point NA-G another unit with some service training which was 7.				
	medical record by t that indicated: on 1 nurse that she did r to her to care for he nurse "I don't like h nurse asked NA if s stated "No." The nu resident was satisfi 10/25/17, further in manager followed u concern, notified re assigned to anothe satisfied. The resid statements of feelir Documentation cor	e was documented in R31's he director of nursing (DON) 0/22/17, R31 complained to not want the new NA assigned er any longer. R31 stated to er, she called me evil." The she called resident evil and NA urse re-assigned NA and ed. The documentation on dicated on 10/23/17, the nurse up with resident on her isident that NA would be r floor and resident was ent did not make any ng verbal abuse occurred. thinued on 10/25/17, noted the				
	resident stated to M of Health) surveyor abused by a NA wh administrator was r	ADH (Minnesota Department that she had been verbally to called her evil. The notified, investigation initiated NA has already been assigned				

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	СОМ	E SURVEY PLETED
		00522	B. WING		- 10/27	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
22000	Continued From pa	age 58	22000			
		unit with extra orientation and will no longer care for the				
	interviewed. The D R31 didn't say she stated she didn't lik new and I just don't people at all." The expectation of staff was made, staff wo and DON immediat complaint/ grievand thought R31 just di nursing assistant. I didn't think it was a situation. The DON to the resident right feel comfortable if t another part of the indicated would be that calling resident and a resident did to	:27 p.m. the DON was DON said "I think at the time was upset about it, but had that person such as, 'she's t like her.' R31 doesn't like new DON further stated her twas if an allegation of abuse buld inform the administrator tely. She added that since a ce form had been used, she'd d not like that particular n addition, the DON said she an emotionally distraught I also stated RN-I had spoken t away and asked if she would they moved that staff to building which R31 had ok. However, the DON verified t's names was verbal abuse, not have to say they were t it o be reported as abuse.				
	R150 had dementia could not complete MDS. The MDS fur extensive assist wit (ADLs) including tra	DS dated, 8/2/17, indicated a and Alzheimer's disease, and the cognitive portion of the ther noted R150 was an th all activities of daily living ansfers and ambulation. port closed 10/6/17, revealed	t			
	that on 10/3/17, at cares R150 had a b which measured 10 the occurrence rep explain how she su	7:30 a.m. during morning bruise on her right inner thigh 0 centimeter (cm) by 9 cm. Per ort, R150 was unable to istained it. Licensed practical , "Res [Resident] must have				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
			A. BOILDING.			
		00522	B. WING			27/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NOF IONY, MN 554			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
22000	Continued From pa	age 59	22000			
	during transfer. Ma indicated." Occurred indicated wound w R150 sometimes re- transfers due to be indicated in the Co dated 10/5/17, at 1 bruise incident. The indicated R150 had cares, striking out a attempt to self-trans indicated resident I pattern and bruise Broda chair, and be happened when R into the chair. Inter "Staff will cont [con assisting this resid- techniques to have The Occurrence R notification of facili nursing. Review of progress 10/24/17, did not re administrator of the notes did not indica on arm of Broda ch The Hospice and F Documentation Re	o the Broda chair arm rest altreatment and abuse is not ence Report wound description as blackened. Report indicated equired assist of two with shaviors. The occurrence report nclusion section of report 1:54 a.m. the IDT reviewed e conclusion section of report d a history of being resistive to at staff during cares, would usfer, R150 required staff offer. Occurrence Report bruise was in a non-hand grasp lined up with the armrest of the ruise was likely to have 150 was attempting to sit down vention implemented was attinue] to use caution when ent and use Montessori e res cooperative with cares." eport did not indicate ty administrator or director of s notes from 9/3/17, through eveal notification of the e bruise. Review of progress ate any instance of R150 sitting nair. Palliative Care Facility Visit cord dated 10/16/17, revealed kious grabbing and upset with				
	cares and had a fa R150's care plan p	nore difficult to redirect with ding bruise on right inner thigh rinted 10/26/17, indicated ist of one staff member for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00522	B. WING		10/27/20	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
ST ANTH	IONY HEALTH & REH		SS ROAD NOF			
				PROVIDER'S PLAN OF		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	lge 60	22000			
	8/23/17, instructed and intervene wher self-transfer and th	The intervention dated staff to monitor R150 closely n resident attempted to at staff would intervene when ent to sit on correct seating as				
	During interview on 10/25/17, at 2:07 p.m. NA-B stated R150 would become aggressive when getting dressed since her fall and was very nervous about rolling over in bed or stand up and R150 would hit staff. NA-B stated R150 had declined in ability to walk. NA-B stated R150 had never R150 sat on the arm of the Broda chair when NA-B transferred her.					
	DON stated whene nurse would chart t report. DON stated what happened and happened or there staff will call the ad could report it. The reported it would us meeting the next da with a conclusion a Regarding R150's i stated R150 was un but R150 had a his aggressive during of have bumped her la asked when the ID stated 10/5/17. DO them the next morr 10/5".DON verified 10/5/17. DON verified	10/26/17, at 12:01 p.m. the ver there was an incident the he incident and start a risk if the resident cannot say d the staff do not know what is an allegation of abuse the ministrator right away, so we DON said if something is not sually be discussed at the IDT ay and the IDT would come up nd put interventions in place. ncident of 10/3/17, DON nable to state what happened tory of being resistive and cares. DON stated R150 must eg during a transfer. When T review the bruise The DON N said, "We always talk about ning, but [R150] wasn't until nurse manager did the IDT on ed that a bruise in the inner ous area. DON stated the				

		(X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	·····	COM	PLETED
		00522	B. WING			C 27/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	-	
τ ΔΝΤΗ	IONY HEALTH & REH		SS ROAD NOF			
		SIANIF	IONY, MN 554			
(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) COMPLE DATE
22000	Continued From pa	age 61	22000			
	when she was info	rmed of the bruise.				
	stated they did not have done the inve wrote it on 10/5/17 tell you. If I looked	n 10/26/17, at 1:16 p.m. RN-D work on 10/3/17, but "I might estigation the following day but ." RN-D said, "I honestly can't at it Wednesday and ould have been 9:30 a.m. after				
	administrator state was reportable if a what happened, it could not figure ou	n 10/26/17, at 2:54 p.m. d if a bruise of unknown origin resident could not tell you was a suspicious area and we t what happened. The unable to say when she was s bruise.				
	The administrator of residents in the factors and de prevention plans to	THOD OF CORRECTION: or designee could assess all sility for vulnerability of abuse velop individual abuse o minimize each residents risks ninistrator or designee could ance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

Preserve Resolution on the preserve on the prese			I AND HUMAN SERVICES E & MEDICAID SERVICES		F5267026	FORM	D: 11/27/2017 APPROVED D: 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STANTHONY HEALTH & REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE Image: Comparing the strength of percencences STANTHONY, NM 55421 Image: Comparing the strength of percencences Image: Comparing the strength of percences Image: Comparing the strength of percences Image: Comparing the strengt of percences Image: Comparine t	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
ST ANTHONY HEALTH & REHABILITATION 3709 F058 ROAD NORTHEAST ST ANTHONY, MN 55421 IVA ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (FLOCH DEFICIENCY MUST BE PRECEDED BY FULL REQUATIONY OR LSC DENTIFYING INFORMATION) D PREFIX TAG PREFIX PREFIX D PREFIX CACH CORRECTION STONE SPLAN OF CORRECTION (EACH CORRECTION STONE SPLAN OF CORRECTION (EACH CORRECTION STONE SPLAN OF CORRECTION (EACH CORRECTION SPLAN OF CORRECTION) (EACH CORRECTION SPLAN OF CORPLANCE UPON THE DEFARTMENT'S ACCEPTANCE UPON THE DEFARTMENT'S ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HEINESSOFT FOR MULL BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HEINESSOFT FOR MULL BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HEINESSOFT FOR MARKED SPLAN ACCORDANCE WITH YOUR VERIFICATION. A an anual Life Safety Code survey was conducted by the Minesota Department of Public Safety. State Fire Marshal Division on October 27, 2017. At the time of this survey, St. Anthony Health and Rehab was found not in in Medicare/Medicare/Medicare 42 CPR, Subpart 483.70(a). Life Safety Code (LSC), Chapter 19 Existing Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			245267	B, WING		10)/27/2017
(M) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECEDENCY) D PREFIX TAG PREVIX PREFIX PREVIX (COMPETING CROSS-REFERENCE OF OTHE APPROPRIATE DEFICIENCY) D COMPETING (CROSS-REFERENCE OF OTHE APPROPRIATE DEFICIENCY) COMPETING (CROSS-REFERENCE OF OTHE APPROPRIATE DEFICIENCY) COMPETING (CROSS-REFERENCE OF OTHE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 K 000 K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEFARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. K 000 UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 27, 2017. At the time of this survey, St. Anthony Health and Renab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of NFPA 99, the Health Care Facilities Code. EEPOECCION PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota SL, Suite 145 EEPOECC					3700 FOSS ROAD NORTHEAST		
Imperior reach obscious as preceded by Full Prierx read read ceodescrete recevent action should be consistered to the period with th							(25)
FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2867 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 27, 2017. At the time of this survey, St. Anthony Health and Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION DATE
THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 27, 2017. At the time of this survey, St. Anthony Health and Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	INITIAL COMMEN	TS	K 00	00		
ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOITOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 27, 2017. At the time of this survey, St. Anthony Health and Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145		FIRE SAFETY					
ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 27, 2017. At the time of this survey, St. Anthony Health and Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145		ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI PAGE OF THE CM	COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE		-		
conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 27, 2017. At the time of this survey, St. Anthony Health and Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145		ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN				
CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145		conducted by the M Public Safety, Stat October 27, 2017. Anthony Health an compliance with th in Medicare/Medic 483.70(a), Life Saf edition of National (NFPA) Standard Chapter 19 Existin edition of NFPA 99	Minnesota Department of e Fire Marshal Division on At the time of this survey, St. d Rehab was found not in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 101, Life Safety Code (LSC), g Health Care and the 2012				
State Fire Marshal Division 445 Minnesota St., Suite 145		CORRECTION FO	OR THE FIRE SAFETY	-	EPOC	1	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		State Fire Marshal	Division				
Electronically Signed 11/22/2			DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 11/22/201

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 provide. 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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	11/27/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	
		245267	B, WING			10/2	7/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	ONY HEALTH & REH	ABILITATION			700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa St. Paul, MN 55101	-	ĸ	000			
	By email to: Marian.Whitney@s Angela.Kappenmar				*		
		RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	without basement to determined to be of facility is fully prote- automatic sprinkler system with smoke spaces open to the automatic fire depa	Center is a 2-story building hat was built in 1967 and was f Type II(111) construction. The cted throughout by an system and has a fire alarm detection in the corridors and corridors that is monitored for artment notification. The facility wall with an assisted living -hour fire rating.					
	The facility has a ca census of 127 at tir	apacity of 140 beds and had a ne of the survey.					
	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: Maintenance and Testing	к	353			11/15/17

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

Event ID: 0QGF21

Facility ID: 00522

If continuation sheet Page 2 of 4

	ENTERS FOR MEDICARE & MEDICAID SERVICES TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 245267		A. BUILDING					
		B. WING		10/27/2017			
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 353	Continued From pa	age 2	K 353				
	Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, insp maintained in a set available.	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked		ч.			
	c) Water system	-					
	any non-required of system. 9.7.5, 9.7.7, 9.7.8, This REQUIREME by: Based on observa facility did not main fire sprinkler system and the 2012 LSC	KS information on coverage for or partial automatic sprinkler and NFPA 25 NT is not met as evidenced ation and document review, the ntain and test their automatic m in accordance with NFPA 25 NFPA 101. 9.7.5, 9.7.7, 9.7.8. tice could effect all 127		 Upcoming sprinkler flow tests w immediately looked at for timelines The next four quarters of sprink testing have been planned. The Maintenance Director remaresponsible for this requirement, to our automatic fire sprinkler flow te 	ss. Ier flow ains o ensure		
	1500 on October 2 revealed that the fa evidence of having	etween the hours of 1000 and 27, 2017, document review acility could not provide g conducted a quarterly for the first quarter of 2017.		conducted quarterly.			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2017 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245267	B, WING	÷		10/	27/2017	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ST ANTH	IONY HEALTH & REH	ABILITATION	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF T A G	XI	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 353	Continued From pa Maintenance Direct	age 3 tor at the time of discovery.	ĸ	353				
FORM CMS-2	567(02-99) Previous Version:	s Obsolete Event ID: 0Q0	GF21	Facility	ID: 00522 If o	continuation sh	neet Page 4 of 4	