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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0QGF
Facility ID: 00522

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245267**
2. STATE VENDOR OR MEDICAID NO. (L2) **369742800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ANTHONY HEALTH & REHABILITATION**
(L4) **3700 FOSS ROAD NORTHEAST**
(L5) **ST ANTHONY, MN** (L6) **55421**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **12/12/2017** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **140** (L18)
13. Total Certified Beds **140** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 140 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 01/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1984** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/18/2017** (L33)

DETERMINATION APPROVAL

**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 deteremined for the complaint investigation number H5267081.

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

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

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

Electronically delivered
January 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, 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 AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

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(L5) **ST ANTHONY, MN** (L6) **55421**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/27/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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|---|---|---|---|---|
| | 140 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Sheila Placido, HFE NEII 11/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/18/2017 (L20)

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

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_X_ 1. Facility is Eligible to Participate
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**07/01/1984**
(L24)

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25. LTC EXTENSION DATE:
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(L44)
B. Rescind Suspension Date:
(L45)

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32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

**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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

**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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245267 | A. BUILDING ______<br>B. WING ______ | C<br>10/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANTHONY HEALTH & REHABILITATION | 3700 FOSS ROAD NORTHEAST<br>ST ANTHONY, MN 55421 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On October 23, 24, 25, 26 and 27, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.<br><br>The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance.<br><br>Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.<br><br>An investigation of complaint H5267081 was completed at the time of the survey and was substantiated at F164, F225, and F226. An investigation of complaint H5267080 was completed and was not substantiated. | F 000 | | |
| F 156<br>SS=D | NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br>CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)<br><br>(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.<br><br>§483.10(g) Information and Communication.<br>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. | F 156 | | 12/6/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245267 | A. BUILDING ______ B. WING ______ | C 10/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ST ANTHONY HEALTH & REHABILITATION** | **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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 156 | Continued From page 1<br><br>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:<br><br>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -<br><br>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;<br><br>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.<br><br>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and<br><br>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, | F 156 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245267 | A. BUILDING ______<br>B. WING ______ | C<br>10/27/2017 |

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| **ST ANTHONY HEALTH & REHABILITATION** | **3700 FOSS ROAD NORTHEAST**<br>**ST ANTHONY, MN 55421** |

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| F 156 | Continued From page 2 | F 156 | | |

exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any

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| F 156 | Continued From page 3<br>suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br><br>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:<br><br>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and<br><br>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.<br><br>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use | F 156 | | |

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| F 156 | Continued From page 4 | F 156 | | |

Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

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| F 156 | Continued From page 5<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.<br><br>(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br><br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br><br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br><br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br><br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. | F 156 | | |

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| F 156 | Continued From page 6<br><br>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide the appropriate notices for discontinuation of services for 2 of 4 residents (R7, R8) who remained in the facility following a Medicare covered stay.<br><br>Findings include:<br><br>R8 received a Notice of Medicare Non-Coverage dated 1/24/17, for a coverage end date of 1/26/17. R8 remained in the facility, with 79 Medicare days remaining but did not receive a determination of continued stay.<br><br>R8 received a Notice of Medicare Non-Coverage but refused to sign, for a coverage end date of 7/24/17. R8 remained in the facility, with 80 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.<br><br>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.<br><br>R7 received a Notice of Medicare Non-Coverage dated 10/27/17, for a coverage end date of | F 156 | St. Anthony Health & Rehabilitation (SAHR) makes its best effort to operate in full compliance with state and federal law. Nothing included in this plan of correction is an admission otherwise. SAHR has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that SAHR may contest the merits and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. Please accept this plan of correction as SAHR's allegation of substantial compliance.<br><br>F156<br>Notice of Rights, Rules, Services, Charges<br><br>1. R7 remains in the facility. R8 has been discharged,<br>2. The appropriate Notice of Medicare Non-Coverage forms have been initiated.<br>3. The facility has developed a Medicare Notice procedure.<br>4. The facility MDS coordinators and | |

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| F 156 | Continued From page 7<br>10/27/17. R7 remained in the facility, with 52 Medicare days remaining but did not receive a determination of continued stay.<br><br>During an interview on 10/27/17, at 7:45 a.m., LSW-A stated the Minimum Data Set (MDS) Coordinator provided education on the Notice of Medicare Non-Coverage. LSW-A further indicated that the MDS Coordinator gave the social workers a form to issue to residents and/or families and make sure they know they have a right to appeal. LSW-A verified they only gave one form (Form CMS 10123) and they also gave a denial letter from Humana if applicable to the resident.<br><br>During an interview on 10/27/17, at 9:38 a.m., the MDS Coordinator verified they were only issuing one letter and did not know about Form CMS 10055 or other appropriate SNF (skilled nursing facility) denial letters.<br><br>During an interview on 10/27/17, at 2:54 p.m., the administrator stated she was "not aware" that Medicare recipients were not receiving both liability notices when they stayed in the facility and had not exhausted their benefits. In addition, the administrator stated she was not aware that more than one type of notice was to be given to the resident or resident's representative and would expect the MDS Coordinators and LSW's to give the correct notice. Lastly, upon entrance, survey team asked for demand bills from the facility and which the facility indicated they did not have any and found during the investigation that the facility called it an appeal rather than demand bill. The administrator stated she was not aware that these were two separate items.<br><br>A facility policy was requested, but not received. | F 156 | Social Workers have been in-serviced on the Medicare Notice procedure.<br>5. Facility leadership will audit 1 end of coverage notice per week for appropriate notice until the next facility QAPI meeting on 12/19/17.<br>6. The facility QA&A committee will review completed audit results and make further recommendations.<br>7. The Executive Director remains responsible for compliance with this requirement, to ensure each resident receives notice of changes in coverage | |

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| F 164 SS=D | PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br>CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2)<br><br>483.10<br>(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>(h)(3)The resident has a right to secure and confidential personal and medical records.<br><br>(i) The resident has the right to refuse the release of personal and medical records except as provided at<br>§483.70(i)(2) or other applicable federal or state laws.<br><br>§483.70<br>(i) Medical records.<br>(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br><br>(i) To the individual, or their resident representative where permitted by applicable law;<br><br>(ii) Required by Law;<br><br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br><br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, | F 164 | | 12/6/17 |

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| F 164 | Continued From page 9<br>law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to maintain privacy of a resident's personal care related information for 1 of 5 residents (R83) reviewed who was dependent upon staff for activities of daily living (ADLs).<br><br>Findings include:<br><br>During observation on 10/25/17, at 1:38 p.m. nursing assistant (NA)-B stood R150 utilizing the mechanical lift in the bathroom. There were two large wet spots on the back of the resident's pants. NA-B said, "Between her and [R83], I don't know who wets the most." Registered nurse (RN)-C who was also present added, "They wet a lot." NA-B remarked, "I would swear these two drank 50 gallons a day and take water pills." NA-B and RN-C made these statements in front of R150 about R83's incontinence.<br><br>R150's quarterly Minimum Data Set (MDS) dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all ADLs and R150 was frequently incontinent of bladder and bowel.<br><br>R83's quarterly MDS dated 9/20/17, indicated R83 had dementia and was unable to complete the cognitive portion of the MDS. The MDS | F 164 | F164<br>Privacy<br><br>1. The identified resident R83 has had her care plans and NAR assignment sheets reviewed and updated as needed to include providing for privacy and dignity.<br>2. The responsible staff were re-educated on privacy and dignity as soon as notified of the concern during the annual survey.<br>3. Staff will be re-trained on providing for resident privacy and dignity using specific examples cited in the CMS-2567.<br>4. Nursing leadership will assess privacy and dignity competency on 6 staff members a week until all nursing staff have been assessed.<br>5. Nursing leadership will also look at potential privacy and dignity issues while completing various scheduled audits such as med pass audits, NAR direct care audits, toileting, etc.<br>6. The Director of Nursing will review the completed audits and bring any identified privacy concerns to the facility QAPI committee for review and further recommendations.<br>7. The Director of Nursing remains responsible for compliance with this requirement to ensure residents the right | |

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| F 164 | Continued From page 10<br>further indicated R83 required extensive assist with all ADLs and R83 was frequently incontinent of bladder and bowel.<br><br>During interview on 10/25/17, at 2:07 p.m. NA-B verified making the statement about R83's incontinence in front of R150 and stated she was nervous.<br><br>During interview on 10/25/17, at 2:22 p.m. RN-C stated she thought NA-B was trying to provide information to explain that all residents were changed every two hours and R83 was changed more often. RN-C confirmed NA-B should have waited to explain that until they were done providing R150's care.<br><br>During interview on 10/25/17, at 2:49 p.m. RN-D stated staff "should be focused on the resident they are working with and not talk about any other resident."<br><br>During interview on 10/26/17, at 2:32 p.m. the director of nursing verified the staff should not have discussed R83 while providing care to R150.<br><br>The facility's Confidentiality policy dated 6/26/12, included: "Staff will not discuss any client information in locations where these conversations may be overheard by unauthorized persons, such as other clients or visitors." | F 164 | to personal privacy and confidentiality.<br>8. See also F241 | |
| F 176 SS=D | RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br>CFR(s): 483.10(c)(7)<br><br>(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by | F 176 | | 12/6/17 |

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| F 176 | Continued From page 11<br>§483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure self-administration of medications was allowed for 1 of 1 resident (R186) only after an assessment determined it was safe.<br><br>Findings include:<br><br>R186's room was observed on 10/24/17, at 10:16 a.m. and an Ventolin inhaler (medication used to open the airway) was observed on top of the resident's nightstand available for use.<br><br>R186 was interviewed on 10/24/17, at 10:45 a.m. R186 said she kept the inhaler on her nightstand and used it when she needed it.<br><br>The Admission Face Sheet on R186's record indicated she had been admitted 5/28/15, with a diagnosis that included chronic obstructive pulmonary disease.<br><br>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)."<br><br>Review of R186's self-administration of medication assessment dated 9/26/17, indicated R186 was to have the nursing staff administer the medication.<br><br>On 10/24/17, at 10:19 a.m. registered nurse-F verified R186 had an order to leave the | F 176 | F176<br>Resident Self Administer Drugs<br><br>1. R186 has had a self administration of medications assessment completed with care plans updated as needed.<br>2. A self-administration of medications assessment has been completed on any other residents wishing to self-administer medications at the bedside.<br>3. Staff will be re-educated on the need for accurate completion of a self-administration of medication for any resident that wishes to self-administer medications.<br>4. Nursing leadership will assess medication administration competency for 5 nurses per week until all Nurses have been assessed.<br>5. Nursing leadership will audit the accuracy of the self administration of medications assessment with each quarterly, annual, or significant change of condition MDS.<br>6. The audits will be reviewed and any identified concerns will be brought to the facility QAPI committee for further recommendations.<br>7. The Director of Nursing remains responsible to ensure residents are assessed for the ability to self-administer medications. | |

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| F 176 | Continued From page 12<br>medication at the bedside, but was not assessed to self-administer the medication. | F 176 | | |
| F 225<br>SS=D | INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>CFR(s): 483.12(a)(3)(4)(c)(1)-(4)<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.<br><br>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.<br><br>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and | F 225 | | 12/6/17 |

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| F 225 | Continued From page 13<br>misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to operationalize their abuse prevention policy for 1 of 1 resident (R31), who alleged verbal abuse with derogatory comments made by staff. In addition, the facility failed to ensure a bruise of unknown origin located on a resident's thigh was reported to the State agency (SA) in a timely manner for 1 of 1 resident (R150). | F 225 | F225<br>Abuse reporting and investigating<br><br>1. The allegation of abuse by R31 has been reported and investigated. The bruise for R150 has been investigated.<br>2. The facility Vulnerable Adult Abuse Prevention policy and procedure has been reviewed and remains appropriate. | |

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| | 245267 | A. BUILDING ______ B. WING ______ | C 10/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST ANTHONY HEALTH & REHABILITATION | 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421 |

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| F 225 | Continued From page 14<br><br>Findings include:<br><br>R31 was admitted to the facility on 3/24/17. The Face Sheet in the resident's record indicated diagnoses including: spinal stenosis of neck, compression fracture of first lumbar vertebra, muscle weakness, diabetes, and history of stroke.<br><br>During an interview with R31 on 10/24/17, at 1:18 p.m. R31 stated she had "complained to a nurse that nursing assistant (NA)-[G] emotionally hurt her when she called her the devil about 20 times." R31 stated "[NA-G] said nobody out here likes you because you're the devil." R31 stated she had reported the incident to the nurse who was working that night.<br><br>R31's care plan dated 7/26/17, directed staff to explain cares and procedures prior to performing, offer validation of feelings, social service note in chart "prefers male care givers", abuse prevention, monitor for all signs and symptoms, accusations of abuse or neglect. Investigate and report all signs and symptoms of abuse or neglect. Staff to assist resident out of dining room to prevent bumping into or altercations with other 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.<br><br>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, | F 225 | 3. The Administrator and DON attended VAA education at Care Providers joint training on 11/7/17.<br>4. Staff have been re-educated on the facility Vulnerable Adult Abuse Prevention policy and program.<br>5. The IDT will review each incident to determine if reportable and appropriate preventative measures are put in place.<br>6. The facility QAPI committee will review all incidents monthly.<br>7. See also F226.<br>8. The Executive Director remains responsible for compliance with this requirement, to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately | |

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| F 225 | Continued From page 15 | F 225 | | |

incontinence cares, and also experienced some pain. The assessment further indicated R31 had no behavioral issues and was not receiving any psychoactive medications.

Registered nurse (RN)-H was interviewed on 10/25/17, at 2:23 p.m. and stated she had received a voicemail from the nurse who had been working on the evening of 10/22/17, regarding R31's complaint of being called the devil. RN-H said she had followed up with R31 the next day. RN-H stated NA-G had denied the incident had ever happened, but was instructed not to take care of R31 again. RN-H said R31 had been satisfied with not having NA-G take care of her, so the concern had been documented on a grievance form. RN-H said R31 "did not call it emotional abuse" so it was not reported to the administrator, director of nursing (DON), or the SA. RN-H further stated that she had received another complaint about NA-G from a daughter of another family, whose roommate 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.

On 10/25/17, a note was documented in R31's medical record by the director of nursing (DON) that indicated: on 10/22/17, R31 complained to nurse that she did not want the new NA assigned to her to care for her any longer. R31 stated to nurse "I don't like her, she called me evil." The

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| F 225 | Continued From page 16<br>nurse asked NA if she called resident evil and NA stated "No." The nurse re-assigned NA and resident was satisfied. The documentation on 10/25/17, further indicated on 10/23/17, the nurse manager followed up with resident on her concern, notified resident that NA would be assigned to another floor and resident was satisfied. The resident did not make any statements of feeling verbal abuse occurred. Documentation continued on 10/25/17, noted the resident stated to MDH (Minnesota Department of Health) surveyor that she had been verbally abused by a NA who called her evil. The administrator was notified, investigation initiated and was on-going NA has already been assigned to another nursing unit with extra orientation and supervision, so NA will no longer care for the resident.<br><br>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's new and I just don't like her.' R31 doesn't like new people at all." The DON further stated her expectation of staff was if an allegation of abuse was made, staff would inform the administrator and DON immediately. She added that since a complaint/ grievance form had been used, she'd thought R31 just did not like that particular nursing assistant. In addition, the DON said she didn't think it was an emotionally distraught situation. The DON also stated RN-I had spoken to the resident right away and asked if she would feel comfortable if they moved that staff to another part of the building which R31 had indicated would be ok. However, the DON verified that calling resident's names was verbal abuse, and a resident did not have to say they were | F 225 | | |

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| F 225 | Continued From page 17 verbally abused for it to be reported as abuse.<br><br>The facility failed to report an allegation of verbal/emotional abuse in a timely manner to the administrator, DON, and State agency and fully investigate the allegation.<br><br>R150's quarterly MDS dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all activities of daily living (ADLs) including transfers and ambulation.<br><br>An Occurrence Report closed 10/6/17, revealed that on 10/3/17, at 7:30 a.m. during morning cares R150 had a bruise on her right inner thigh which measured 10 centimeter (cm) by 9 cm. Per the occurrence report, R150 was unable to explain how she sustained it. Licensed practical nurse documented, "Res [Resident] must have bumped herself into the Broda chair arm rest during transfer. Maltreatment and abuse is not indicated." Occurrence Report wound description indicated wound was blackened. Report indicated R150 sometimes required assist of two with transfers due to behaviors. The occurrence report indicated in the Conclusion section of report dated 10/5/17, at 11:54 a.m. the IDT reviewed bruise incident. The conclusion section of report indicated R150 had a history of being resistive to cares, striking out at staff during cares, would attempt to self-transfer, R150 required staff assistance to transfer. Occurrence Report indicated resident bruise was in a non-hand grasp pattern and bruise lined up with the armrest of the Broda chair, and bruise was likely to have happened when R150 was attempting to sit down into the chair. Intervention implemented was | F 225 | | |

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| F 225 | Continued From page 18 | F 225 | | |

"Staff will cont [continue] to use caution when assisting this resident and use Montessori techniques to have res cooperative with cares." The Occurrence Report did not indicate notification of facility administrator or director of nursing.

Review of progress notes from 9/3/17, through 10/24/17, did not reveal notification of the administrator of the bruise. Review of progress notes did not indicate any instance of R150 sitting on arm of Broda chair.

The Hospice and Palliative Care Facility Visit Documentation Record dated 10/16/17, revealed R150 was very anxious grabbing and upset with cares. R150 was more difficult to redirect with cares and had a fading bruise on right inner thigh.

R150's care plan printed 10/26/17, indicated R150 required assist of one staff member for transfers from 8/8/17 until 10/24/17, when care plan was updated. The intervention dated 8/23/17, instructed staff to monitor R150 closely and intervene when resident attempted to self-transfer and that staff would intervene when able to assist resident to sit on correct seating as able.

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.

During interview on 10/26/17, at 12:01 p.m. the

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| F 225 | Continued From page 19<br>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 nurse manager did the IDT on 10/5/17. 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.<br><br>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."<br><br>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 administrator was unable to say when she was | F 225 | | |

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| F 225 | Continued From page 20 | F 225 | | |

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 disability.
7. Physical Abuse includes, but not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.
9. Neglect is the failure of the facility, it's

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| F 225 | Continued From page 21<br>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. | F 225 | | |
| F 226<br>SS=D | DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br>CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3)<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of | F 226 | | 12/6/17 |

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| F 226 | Continued From page 22<br>resident property<br><br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>The facility Abuse, Neglect and Exploitation policy approved 11/28/16, indicated mandated reporters will immediately report to the:<br>" Administrator/Executive Director<br>" Other Officials in accordance with State Law<br>" State Survey and Certification agency following state protocols.<br>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 | F 226 | F226<br>Abuse policy<br><br>1. The allegation of abuse by R31 has been reported and investigated. The bruise for R150 has been investigated.<br>2. The facility Vulnerable Adult Abuse Prevention policy and procedure has been reviewed and remains appropriate.<br>3. The Administrator and DON attended VAA education at Care Providers joint training on 11/7/17.<br>4. Staff have been re-educated on the facility Vulnerable Adult Abuse Prevention policy and program.<br>5. The IDT will review each incident to determine if reportable and appropriate preventative measures are put in place.<br>6. The facility QAPI committee will review all incidents monthly.<br>7. See also F225.<br>8. The Executive Director remains responsible for compliance with this requirement, to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately | |

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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 disability.

7. Physical Abuse includes, but not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

9. Neglect is the failure of the facility, it's 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.

During an interview with R31 on 10/24/17, at 1:18 p.m. R31 stated she had "complained to a nurse that nursing assistant (NA)-[G] emotionally hurt her when she called her the devil about 20 times." R31 stated "[NA-G] said nobody out here likes you because you're the devil." R31 stated she had reported the incident to the nurse who was working that night.

R31 was admitted to the facility on 3/24/17. The Face Sheet in the resident's record indicated diagnoses including: spinal stenosis of neck, compression fracture of first lumbar vertebra, muscle weakness, diabetes, and history of stroke.

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| F 226 | Continued From page 24<br><br>R31's care plan dated 7/26/17, directed staff to explain cares and procedures prior to performing, offer validation of feelings, social service note in chart "prefers male care givers", abuse prevention, monitor for all signs and symptoms, accusations of abuse or neglect. Investigate and report all signs and symptoms of abuse or neglect. Staff to assist resident out of dining room to prevent bumping into or altercations with other 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.<br><br>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, incontinence cares, and also experienced some pain. The assessment further indicated R31 had no behavioral issues and was not receiving any psychoactive medications.<br><br>Registered nurse (RN)-H was interviewed on 10/25/17, at 2:23 p.m. and stated she had received a voicemail from the nurse who had been working on the evening of 10/22/17, regarding R31's complaint of being called the devil. RN-H said she had followed up with R31 the next day. RN-H stated NA-G had denied the incident had ever happened, but was instructed not to take care of R31 again. RN-H said R31 had been satisfied with not having NA-G take care of her, so the concern had been documented on a grievance form. RN-H said R31 "did not call it emotional abuse" so it was not | F 226 | | |

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reported to the administrator, director of nursing (DON), or the SA. RN-H further stated that she had received another complaint about NA-G from a daughter of another family, whose roommate 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.

On 10/25/17, a note was documented in R31's medical record by the director of nursing (DON) that indicated: on 10/22/17, R31 complained to nurse that she did not want the new NA assigned to her to care for her any longer. R31 stated to nurse "I don't like her, she called me evil." The nurse asked NA if she called resident evil and NA stated "No." The nurse re-assigned NA and resident was satisfied. The documentation on 10/25/17, further indicated on 10/23/17, the nurse manager followed up with resident on her concern, notified resident that NA would be assigned to another floor and resident was satisfied. The resident did not make any statements of feeling verbal abuse occurred. Documentation continued on 10/25/17, noted the resident stated to MDH (Minnesota Department of Health) surveyor that she had been verbally abused by a NA who called her evil. The administrator was notified, investigation initiated and was on-going NA has already been assigned to another nursing unit with extra orientation and supervision, so NA will no longer care for the resident.

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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's new and I just don't like her.' R31 doesn't like new people at all." The DON further stated her expectation of staff was if an allegation of abuse was made, staff would inform the administrator and DON immediately. She added that since a complaint/ grievance form had been used, she'd thought R31 just did not like that particular nursing assistant. In addition, the DON said she didn't think it was an emotionally distraught situation. The DON also stated RN-I had spoken to the resident right away and asked if she would feel comfortable if they moved that staff to another part of the building which R31 had indicated would be ok. However, the DON verified that calling resident's names was verbal abuse, and a resident did not have to say they were verbally abused for it to be reported as abuse.
R150's quarterly MDS dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all activities of daily living (ADLs) including transfers and ambulation.

An Occurrence Report closed 10/6/17, revealed that on 10/3/17, at 7:30 a.m. during morning cares R150 had a bruise on her right inner thigh which measured 10 centimeter (cm) by 9 cm. Per the occurrence report, R150 was unable to explain how she sustained it. Licensed practical nurse documented, "Res [Resident] must have bumped herself into the Broda chair arm rest during transfer. Maltreatment and abuse is not indicated." Occurrence Report wound description

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indicated wound was blackened. Report indicated R150 sometimes required assist of two with transfers due to behaviors. The occurrence report indicated in the Conclusion section of report dated 10/5/17, at 11:54 a.m. the IDT reviewed bruise incident. The conclusion section of report indicated R150 had a history of being resistive to cares, striking out at staff during cares, would attempt to self-transfer, R150 required staff assistance to transfer. Occurrence Report indicated resident bruise was in a non-hand grasp pattern and bruise lined up with the armrest of the Broda chair, and bruise was likely to have happened when R150 was attempting to sit down into the chair. Intervention implemented was "Staff will cont [continue] to use caution when assisting this resident and use Montessori techniques to have res cooperative with cares." The Occurrence Report did not indicate notification of facility administrator or director of nursing.

Review of progress notes from 9/3/17, through 10/24/17, did not reveal notification of the administrator of the bruise. Review of progress notes did not indicate any instance of R150 sitting on arm of Broda chair.

The Hospice and Palliative Care Facility Visit Documentation Record dated 10/16/17, revealed R150 was very anxious grabbing and upset with cares. R150 was more difficult to redirect with cares and had a fading bruise on right inner thigh.

R150's care plan printed 10/26/17, indicated R150 required assist of one staff member for transfers from 8/8/17 until 10/24/17, when care plan was updated. The intervention dated 8/23/17, instructed staff to monitor R150 closely

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and intervene when resident attempted to self-transfer and that staff would intervene when able to assist resident to sit on correct seating as able.

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.

During interview on 10/26/17, at 12:01 p.m. the 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 nurse manager did the IDT on 10/5/17. 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.

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| F 226 | Continued From page 29<br><br>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."<br><br>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 administrator was unable to say when she was informed of R150's bruise. | F 226 | | |
| F 241 SS=D | DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1)<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident’s individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide care in a dignified manner for 1 of 5 residents (R150) who required assistance with activities of daily living.<br><br>Findings include:<br><br>During observation on 10/25/17, at 1:38 p.m. nursing assistant (NA)-B stood R150 utilizing the mechanical lift in the bathroom. There were two large wet spots on the back of the resident's | F 241 | F241<br>Dignity and Respect of Individuality<br><br>1. The identified resident R150 has had her care plans and NAR assignment sheets reviewed and updated as needed to include providing for privacy and dignity.<br>2. The responsible staff were re-educated on privacy and dignity as soon as notified of the concern during the annual survey. | 12/6/17 |

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| F 241 | Continued From page 30<br>pants. NA-B said, "Between her and [another resident's name], I don't know who wets the most." Registered nurse (RN)-C who was also present added, "They wet a lot." NA-B remarked, "I would swear these two drank 50 gallons a day and take water pills." NA-B and RN-C made these statements in front of R150.<br><br>R150's quarterly Minimum Data Set (MDS) dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all ADLs and R150 was frequently incontinent of bladder and bowel.<br><br>During interview on 10/25/17, at 2:07 p.m. NA-B verified making the statements in front of R150 and stated she was nervous.<br><br>During interview on 10/25/17, at 2:22 p.m. RN-C stated she thought NA-B was trying to provide information to explain that all residents were changed every two hours. RN-C confirmed NA-B should have waited to explain that until they were done providing R150's care. | F 241 | 3. Staff will be re-trained on providing for resident privacy and dignity using specific examples cited in the CMS-2567.<br>4. Nursing leadership will assess privacy and dignity competency on 6 staff members a week until all nursing staff have been assessed.<br>5. Nursing leadership will also look at potential privacy and dignity issues while completing various scheduled audits such as med pass audits, NAR direct care audits, toileting, etc.<br>6. The Director of Nursing will review the completed audits and bring any identified privacy concerns to the facility QAPI committee for review and further recommendations.<br>7. The Director of Nursing remains responsible for compliance with this requirement to ensure residents the right to personal privacy and confidentiality.<br>8. See also F164 | |
| F 246 SS=D | REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br>CFR(s): 483.10(e)(3)<br><br>483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:<br><br>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the | F 246 | | 12/6/17 |

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| F 246 | Continued From page 31<br>resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure a call light was easily accessible in order to summon staff assistance for 1of 6 residents (R26) observed to have a call light not in within reach.<br><br>Findings include:<br><br>R26's care plan effective 1/26/15, to present, indicated R26 had impaired vision and instructed staff to keep the call light with-in reach.<br><br>R26's annual Minimum Data Set (MDS) dated 9/22/17, indicated R26 had moderate cognitive impairment and required extensive assistance from two staff members for activities of daily living (ADLs) that involved mobility. The MDS also identified R26 for being at risk for falls.<br><br>On 10/23/17, at 4:19 p.m. R26 was observed in their room, seated in a manual wheelchair, near the end of the bed facing the wall. R26's call light button placed under the mattress and R26 was unable to reach the call light. R26 indicated she did use the call light to get staff. At 4:19 p.m. licensed practical nurse (LPN)-B verified the call light was not within R26's reach and proceeded to reposition the call light for R26's so it was within the reach.<br><br>During an interview on 10/26/17, at 9:00 a.m. the director of nursing said call lights should be checked every time there was staff in the room; whoever walked in that room should be checking.<br><br>The facility policy titled accessible call lights dated | F 246 | F246<br>Accommodation of Needs<br><br>1. Resident R28 care plans and NAR assignment sheets have been reviewed and updated as needed.<br>2. Staff will be re-trained on providing for resident accommodation of needs, using specific survey examples cited in the 2567.<br>3. Facility leadership will complete call light placement audits 2x/week until the next QAPI meeting 12/19/17.<br>4. The Director of Nursing will review the completed audits and bring any identified concerns to the facility QAPI committee for review and further recommendations.<br>5. The Executive Director remains responsible for compliance with this requirement to ensure residents are provided services with reasonable accommodation of individual needs. | |

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| F 246 | Continued From page 32<br>11/20/15, directed the facility to determine the resident had a call light with reach. The policy included: "Call lights must always be placed in the reach of the resident." | F 246 | | |
| F 250 SS=D | PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br>CFR(s): 483.40(d)<br><br>(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide adequate assessment and services for 1 of 1 resident (R186) diagnosed with mental illness symptoms affecting activities of daily living (ADL) regarding poor appetite.<br><br>Findings include:<br><br>R186's admission note dated 5/19/15, by the certified nurse practitioner (CNP), indicated R186 weighed 68.5 pounds and had a BMI (body mass index) of 11.8.<br><br>R186's admission diagnoses report dated 5/28/15, included diagnoses of bipolar disorder (mental illness that causes shifts in ability to think clearly) and anorexia (an eating disorder characterized by self-starvation).<br><br>R186's care plan, effective 5/29/15 to current, indicated R186 had inadequate food intake related to poor appetite and instructed staff to encourage oral intake and intervene when | F 250 | F250<br>Provision of Medical Related Social Service<br><br>1. R186 was immediately offered psychology services, and refused. SS to continue to offer psychology services to resident at each care conference and PRN.<br>2. All residents in the building were reviewed for appropriate of psychology services, and assessed by psychology as desired by resident.<br>3. The facility has developed a psychology referral procedure.<br>4. Social Service staff educated on the psychology referral procedure.<br>5. All staff has been assigned the course mental health needs of the older adult in HCA for the month of December.<br>6. All residents will continue to be reviewed for appropriate psychology services during every care conference.<br>7. The facility QAPI committee will review | 12/6/17 |

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| F 250 | Continued From page 33<br>appropriate.<br><br>R186's clinical note from the facility social worker dated 1/9/17, indicated R186 had a poor appetite and social services would monitor and follow up as needed.<br><br>R186's ADL verification worksheets dated 8/31/17 through 10/25/17, indicated R186 consumed ate a small percentage of one to two meals per day.<br><br>The Care Conference note dated 10/5/17, indicated R186 refused dietary supplements and had a poor intake at meal time.<br><br>On 10/26/17, R186's weight was documented as 69.0 pounds. R186 weight loss needs were not followed up on per the social note of 1/9/17.<br><br>On 10/25/17, at 9:10 a.m., R186's treating physician was interviewed and said he did not remember writing an order for a psychiatric consultation and he thought social services took care of that.<br><br>During an interview on 10/25/17, at 10:32 a.m. registered nurse (RN)-F said the physician usually wrote an order for a psychiatric consult and R186 did not have an order for a consultation.<br><br>A clinical note dated 10/25/17, during the survey process, at 12:08 p.m. indicated the facility social worker met with R186 and offered in-house psychology services.<br><br>During an interview on 10/26/17, at 9:02 a.m., the director of nursing said she expected psychiatric consultations would be offered to residents with | F 250 | residents receiving psychology services and make further recommendations.<br>8. The Executive Director remains responsible for compliance with this requirement, to ensure that residents receive social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. | |

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| F 250 | Continued From page 34<br>psychiatric diagnoses and social services should have requested psychiatric consultation.<br><br>During an interview on 10/26/17, at 11:38 a.m., the facility dietician said she had not done an assessment of R186 nutrition, as she was new to the facility. The dietician stated R186 would have benefitted from a psychiatric consult to better understand why R186 was not eating. The current dietician could not find evidence in the medical record of a nutritional assessment being completed.<br><br>The facility policy titled mental health services dated 1/30/13, indicated social services will be notified by nursing staff of need for mental health intervention and nursing is to acquire a doctor's order and notify social services. It indicated social services will contact the contracted mental health provider for services. | F 250 | | |
| F 282 SS=D | SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>CFR(s): 483.21(b)(3)(ii)<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 3 residents (R29) reviewed for urinary incontinence. | F 282 | F282<br>Services Provided per Care Plan<br><br>1. Resident R29 s care plans and NAR | 12/6/17 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 282 | Continued From page 35<br><br>Findings include:<br><br>R29's face sheet dated 10/2013, indicated current diagnoses of dementia without behavioral disturbance and osteoarthritis. R29's annual Minimum Data Set (MDS) dated 8/23/17, indicated absence of spoken words regarding speech clarity and severely impaired cognition. R29 required extensive assist of one person to transfer to or from bed, chair, wheelchair and one person extensive assist for toilet use including cleansing self after elimination and pad changes. R29's care area assessment (CAA) for communication, dated 9/1/17, indicated resident was never/rarely understood verbally and resident did not speak and was deaf. CAA for urinary incontinence and indwelling catheter indicated R29 was frequently incontinent, required extensive assist of one staff for toileting and was not able to manage incontinence, change her pads, or take care of own pericares.<br><br>R29's care plan, effective date 10/30/17, to present, indicated resident's alteration in bowel and bladder function due to dementia, frequent incontinence of bowel and bladder directed facility staff to offer toileting upon rising, before/after meals, HS (at bedtime), NOC (at night) rounds and PRN (as needed) AX1 (assist times 1). AX1 with pad change and pericare after incontinence every shift.<br><br>Garden Court NA (Nursing Assistant) Report Sheet, not dated, indicated R29 was incontinent of bowel and bladder, was to offer toileting upon rising, before/after meals, HS, NOC rounds and PRN AX1. | F 282 | sheets reviewed and revised as needed to reflect current bladder incontinence status.<br>2. Other residents will have their Toileting care plans updated with each quarterly, annual, or significant change of condition MDS.<br>3. Staff will be in-serviced on following care plan interventions/NAR assignment sheets and toileting schedules using specific survey findings as an example.<br>4. Nursing leadership will complete toileting competencies on 8 staff per week until all NAR staff have been completed.<br>5. The facility QAPI committee will review completed toileting competency results and make further recommendations.<br>6. See also F312<br>7. The Director of Nursing remains responsible for compliance with this requirement, to ensure that services are provided in accordance with each resident s plan of care. | |

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| F 282 | Continued From page 36<br>During continuous observation on 10/25/17, at 7:18 a.m. to 10:29 a.m., for incontinence care:<br>-At 7:18 a.m., R29 was brought into Garden Court dining room via wheel chair.<br>-From 8:08 a.m. to 8:58 a.m., R29 was observed eating breakfast with staff assist, then brought to Garden Court day room by staff.<br>-At 9:02 a.m., NA-A was observed to place the gait belt around the R29's waist, transferred R29 from wheelchair to day room chair.<br>-From 9:24 a.m. to 9:47 a.m., R29 observed with eyes closed in the day room.<br>-From 9:49 a.m. to 10:12 a.m., R29 was awake and observed watching television and interacting with staff.<br>-From 10:29 a.m. to 10:41 a.m., R29 continued to sit in day room chair.<br><br>During an interview on 10/25/17, at 10:41 a.m., when asked NA-B if R29 was offered or if incontinence care was done stated "I'll take her to the bathroom when I get back from break." NA-B further stated R29 usually goes every three hours and does not void much and was usually dry when she took her to the bathroom. NA-B verified she had not taken R29 that morning, in reference to toileting R29. NA-B further stated that NA-A "felt to see if she was dry before she transferred her to the other chair, before she sat her down. You can usually tell if the pad is heavy."<br><br>During an interview on 10/25/17, at 10:55 a.m., when asked to describe how R29 was checked for incontinence NA-A indicated she "padded her bottom to make sure that she was dry" before resident was transferred to the regular chair in the day room.<br><br>During an interview on 10/25/17, at 11:11 a.m., | F 282 | | |

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| F 282 | Continued From page 37<br>when asked what her expectations of staff was for incontinence care, registered nurse (RN)-D stated staff should follow the care plan and expected a pad check, prefer to check in private. 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. RN-D stated she would prefer to do a visual pad check in a private area.<br><br>During an interview with the director of nursing (DON) when asked if she would expect staff to check R29's incontinence pad in the day room, she stated "no, I expect them to do it in a private area."<br><br>Facility policy for following the care plan was requested, policy titled "Comprehensive Care Plans" was given. | F 282 | | |
| F 312 SS=D | ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>CFR(s): 483.24(a)(2)<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 5 residents (R29) reviewed who was dependent on staff assistance with toileting, received care and services in a timely manner.<br><br>Findings include: | F 312 | F312<br>ADLs<br><br>1. Resident R29 s care plans and NAR sheets reviewed and revised as needed to reflect current bladder incontinence status.<br>2. Other residents will have their Toileting | 12/6/17 |

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| F 312 | Continued From page 38<br>R29's face sheet dated 10/2013, indicated diagnoses including: dementia without behavioral disturbance and osteoarthritis. R29's annual Minimum Data Set (MDS) dated 8/23/17, indicated the resident had an absence of spoken words regarding speech clarity and had severely impaired cognition. R29 required extensive assist of one person to transfer to or from bed, chair, or wheelchair, and required extensive assist of one person for toilet use including cleansing self after elimination and pad changes. R29's care area assessment (CAA) for communication, dated 9/1/17, indicated the resident was never/rarely understood verbally, did not speak and was deaf. CAA for urinary incontinence and indwelling catheter indicated R29 was frequently incontinent, required extensive assist of one staff for toileting and was not able to manage incontinence, change her pads, or take care of own pericares.<br><br>R29's care plan, effective date 10/30/17, to present, indicated resident's alteration in bowel and bladder function due to dementia, frequent incontinence of bowel and bladder directed facility staff to offer toileting upon rising, before/after meals, HS (at bedtime), NOC (at night) rounds and PRN (as needed) AX1 (assist times 1). AX1 with pad change and pericare after incontinence every shift.<br><br>The Garden Court NA (nursing assistant) Report Sheet, not dated, indicated R29 was incontinent of bowel and bladder, was to offer toileting upon rising, before/after meals, HS, NOC rounds and PRN AX1.<br><br>During continuous observation on 10/25/17, at 7:18 a.m. to 10:29 a.m., for incontinence care:<br>-At 7:18 a.m., R29 was brought into Garden Court | F 312 | care plans updated with each quarterly, annual, or significant change of condition MDS.<br>3. Staff will be in-serviced on following care plan interventions/NAR assignment sheets and toileting schedules using specific survey findings as an example.<br>4. Nursing leadership will complete toileting competencies on 8 staff per week until all NAR staff have been completed.<br>5. The facility QAPI committee will review completed toileting competency results and make further recommendations.<br>6. See also F282<br>7. The Director of Nursing remains responsible for compliance with this requirement, to ensure that residents receive the appropriate treatment and services to improve/maintain ADLS. | |

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| F 312 | Continued From page 39 | F 312 | | |

dining room via wheel chair.
-From 8:08 a.m. to 8:58 a.m., R29 was observed eating breakfast with staff assist, then brought to Garden Court day room by staff.
-At 9:02 a.m., nursing assistant (NA)-A was observed to place the gait belt around the R29's waist, transferred R29 from wheelchair to day room chair.
-From 9:24 a.m. to 9:47 a.m., R29 observed with eyes closed in the day room.
-From 9:49 a.m. to 10:12 a.m., R29 was awake and observed watching television and interacting with staff.
-From 10:29 a.m. to 10:41 a.m., R29 continued to sit in day room chair.

During an interview on 10/25/17, at 10:41 a.m., when asked NA-B if R29 was offered or if incontinence care was done stated "I'll take her to the bathroom when I get back from break." NA-B further stated that R29 usually goes every three hours and does not void much and was usually dry when she took her to the bathroom. NA-B verified she had not taken R29 that morning, in reference to toileting R29. NA-B further stated that NA-A "felt to see if she was dry before she transferred her to the other chair, before she sat her down. You can usually tell if the pad is heavy."

During an interview on 10/25/17, at 10:55 a.m., when asked to describe how R29 was checked for incontinence NA-A indicated she "padded her bottom to make sure that she was dry" before resident was transferred to the regular chair in the day room.

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

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| F 312 | Continued From page 40<br>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.<br><br>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." | F 312 | | |
| F 333<br>SS=E | RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br>CFR(s): 483.45(f)(2)<br><br>483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure residents were free of significant medication errors for 4 of 20 residents (R221, R15, R127, R57) who received Lantus (a long acting insulin used for the treatment of elevated blood sugars), and for 1 of 8 residents (R57) who received NovoLog (a short acting insulin for the treatment of elevated blood | F 333 | F333<br>Significant Medication errors<br><br>1. The identified expired insulins were removed from the med carts as soon as notified about the concern during the annual survey.<br>2. R221, R15, R127, and R57 have had a | 12/6/17 |

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| F 333 | Continued From page 41<br>sugars).<br><br>Findings include:<br><br>R221's five-day Minimum Data Set (MDS) dated 9/14/17, indicated R221 was cognitively intact, received insulin injections seven days a week and had a diagnosis of diabetes mellitus (a disease where blood sugars are too high) with polyneuropathy (nerve damage related to diabetes).<br><br>During medication administration observation on 10/23/17, at 7:12 p.m. licensed practical nurse (LPN)-C prepared R221's Lantus 22 units. The vial of Lantus was dated as opened 9/18/17. Prior to LPN-C entering R221's room surveyor stopped LPN-C and had him check the expiration date on the vial. LPN-C verified the Lantus was expired 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.<br><br>R221's October 2017 Medication Administration Records (MAR) 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 101mg/dl-207mg/dl during the period of time from 10/16 through 10/23/17.<br><br>R15's quarterly MDS dated 9/9/17, indicated R15 was moderately independent with decision making, received insulin injections seven days a week and had a diagnosis of diabetes mellitus. | F 333 | 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.<br>3. All other residents with an order for Insulin have had their insulin checked for expiration dates.<br>4. Licensed Nurses will be in-serviced on medication administration and storage<br>5. Licensed Nurses have been assigned education on medication administration and Diabetes through Health Care Academy to be completed by 12/6/17.<br>6. PharMerica Nurse Consultant will conduct a medication administration and storage audit on 11/28/17 and 11/29/17.<br>7. All Nurses will complete a medication storage self competency each shift they work until the next QAPI meeting 12/19/17.<br>8. Nursing leadership will complete Medication administration competency assessments on 5 Nurses per week until all Nurses have been assessed.<br>9. Nursing leadership will complete 5 medication storage competency audits weekly until the next QAPI meeting 12/19/17.<br>10. The facility QAPI committee will review completed audits and medication error reports monthly and make further recommendations.<br>11. See also F431.<br>12. The Director of Nursing remains responsible to ensure residents are free of any significant medication errors. | |

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During medication cart observation on 10/23/17, at 7:21 p.m. Lantus vial for R15 was observed with a date open of 9/22/17. LPN-D verified the vial had been dated as opened 9/22/17, and stated Lantus was only good for 28 days. R15 stated R15 had received Lantus that day. Twenty-eight days from 9/22/17, was 10/19/17.

R15's October 2017 MAR revealed R15 had an order dated 9/26/17, for Lantus 12 units daily. R15 received Lantus 20 units from 10/1/17, through 10/23/17. R15 received Lantus from an expired vial for four days. R15's blood sugars varied from 124mg/dl-278 mg/dl during the period of time from 10/19/ through 10/23/17.

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.

During medication cart observation on 10/23/17, at 7:24 p.m. Lantus vial for R127 was observed with a sticker on it that indicated date open of 9/17/17, and expiration date of 10/15/17. Registered nurse (RN)-G stated R127 was currently in the hospital and had been admitted to the hospital on 10/28/17. RN-G verified date on Lantus vial indicated it had been opened 9/17/17, and stated Lantus was only good for 28 days.

R127's October 2017 MAR revealed R127 had an order dated 10/9/17, for Lantus 20 units daily. R127 had received Lantus 20 units from 10/11-10/19/17. R127 received Lantus from an expired vial for four days after it expired.

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R127 Occurrence report closed 10/25/17, indicated R127's Lantus vial was opened 9/17/17, and should have been discarded 10/15/17.

R57's quarterly MDS dated 9/20/17, indicated R57 was severely cognitively impaired received insulin injections seven days a week and had a diagnosis of diabetes mellitus.

During medication cart observation on 10/24/17, at 9:46 a.m. Lantus vial for R57 was observed with a sticker on it that indicated date open of 9/21/17, LPN-E verified R57 received Lantus that morning. LPN-E stated she had given the Lantus and for some reason had not checked the date the Lantus vial was opened. LPN-E stated the vial should have been disposed of on 10/18/17. LPN-E verified R57 had a vial of NovoLog in the medication cart dated opened 9/21/17 which should have been disposed of at the end of the day on 10/18/17. LPN-E stated R57 had not received NovoLog that day. LPN-E stated an expired medication that was given would be a medication error.

During interview on 10/24/17, at 10:01 a.m. RN-D stated giving expired insulin would be a medication error.

R57's October 2017 MAR revealed R57 had an order dated 8/3/17, for Lantus 20 units daily. R57 had received Lantus 20 units from 10/1/17, through 10/24/17. R57 received Lantus from an expired vial for six days after it expired. R57's October Medication Administration Records revealed R57 had an order dated 9/18/17, for Novolog insulin three times a day based on blood sugars greater than 249 mg/dl. R57 had received

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| F 333 | Continued From page 44<br>six doses of Novolog insulin after 10/18/17.<br><br>During interview on 10/24/17, at 1:04 p.m. facility Medical Director giving a resident expired insulin would be a medication error.<br><br>During interview on 10/26/17, at 2:32 p.m. the director of nurses (DON) stated she would have expected the nurses to check the date open for any vial of insulin and if expired the nurses would not give the expired insulin. The DON stated Lantus and NovoLog are only good for 28 days from the time they were removed from the fridge or when they were opened. The DON stated giving expired insulin would be a medication error.<br><br>Food and Drug Administration Novolog drug insert NDA 20-986/S-032 dated 2006, indicated "NovoLog in unopened vials, cartridges, and NovoLog FlexPen Prefilled syringes should be stored between 2° and 8℃ (36° to 46℉). Do not freeze. Do not use NovoLog if it has been frozen or exposed to temperatures that exceed 37℃ (98.6℉). After a vial, cartridge, or Prefilled syringe has been punctured, it may be kept at temperatures below 30℃ (86℉) for up to 28 days, but should not be exposed to excessive heat or sunlight."<br><br>Sanofi-aventis Lantus medication insert revised 8/2015, indicated Lantus could be stored for 28 days at room temperature if the vial was opened or unopened.<br><br>Medication Administration Subcutaneous Insulin policy dated 5/16, instructed staff, "5. Obtain insulin. Check expiration date. If refrigerated, allow warming to room temperature. ... 6. Date | F 333 | | |

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| F 333 | Continued From page 45<br>vial or device after first use." | F 333 | | |
| F 356<br>SS=C | POSTED NURSE STAFFING INFORMATION<br>CFR(s): 483.35(g)(1)-(4)<br><br>483.35<br>(g) Nurse Staffing Information<br>(1) Data requirements. The facility must post the following information on a daily basis:<br><br>(i) Facility name.<br><br>(ii) The current date.<br><br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br><br>(A) Registered nurses.<br><br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)<br><br>(C) Certified nurse aides.<br><br>(iv) Resident census.<br><br>(2) Posting requirements.<br><br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br><br>(ii) Data must be posted as follows:<br><br>(A) Clear and readable format.<br><br>(B) In a prominent place readily accessible to | F 356 | | 12/6/17 |

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| **ST ANTHONY HEALTH & REHABILITATION** | **3700 FOSS ROAD NORTHEAST**<br>**ST ANTHONY, MN 55421** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 356 | Continued From page 46<br>residents and visitors.<br><br>(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation and interview, the facility failed to update their staff posting when changes occurred in the actual staffing. This had the potential to affect all residents, families and visitors.<br><br>Findings include:<br><br>A review of actual staffing sheets and actual staff postings revealed:<br>On 5/4/17, one additional nursing assistant (NA) on the day shift than on the staff posting.<br><br>On 6/27/17, the staff posting was not updated and did not match the actual staffing schedule. Staff posting incorrectly counted three registered nurses (RNs) when two worked and onelicensed practical nurse (LPN) filled RN spot and was counted as RN not LPN. A medication transcription error occurred on the day shift.<br><br>On 7/14/17, a nurse call in and was replaced by a trained medication aide (TMA), an aide called in and was replaced by a NA. The staff posting was not updated and did not match the actual staffing | F 356 | F356<br>Posted Nurse Staffing Information<br><br>1. The facility s policy on posted staffing information was reviewed and remains appropriate.<br>2. Nursing Staff will receive training regarding posted Nurse Staffing Information, including a step-by-step procedure, for all Nursing Supervisors<br>3. The staffing coordinator will review and verify each day s staffing posting.<br>4. Nursing Leadership will audit the posted nurse staffing information 3x/week until the next QAPI committee meeting 12/19/17.<br>5. The Director of Nursing will review the completed audits and bring any identified concerns to the facility QAPI committee for review and further recommendations.<br>6. The Executive Director remains responsible for compliance with this requirement that Nurse Staffing is posted. | |

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| F 356 | Continued From page 47<br>schedule, one RN was lacking, one NA over the posted count. A resident on subacute fell and sustained a fracture.<br><br>On 8/3/17, two NA's called in for the night shift, one LPN called in on the day shift. One RN and one NA called in for the evening shift. One NA called in for the day shift. The DON worked the subacute unit as facility charge nurse on the night shift.<br><br>On 8/4/17, the staff posting was not updated and did not match the actual staffing schedule, Staff posting listed two RN's, three RN's worked. One additional LPN on schedule that was not on the staff posting. The night shift listed two RN and two LPN's post actual worked schedule was one RN and three LPNs.<br><br>On 8/17/17, one LPN day shift calling and two NA on evening shift called in. The staff posting was not updated and did not match the actual staffing schedule, one NA on orientation was counted as part of staff, although the DON and staffing coordinator stated they were not counted in staff.<br><br>On 9/13/17, the staff posting was not updated and did not match the actual staffing schedule on any shift. One RN was replaced by an LPN on the actual schedule. NA's higher than posted schedule. One RN was replaced by two LPN on night shift.<br><br>On 9/14/17, the staff posting was not updated and did not match the actual staffing schedule on any shift, two LPN's were counted on the day staff posting, but were not found on the actual schedule. Two NA's lacking on evening shift. One additional LPN on night shift. | F 356 | | |

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| F 356 | Continued From page 48<br><br>On 10/1/17, the staff posting was requested by not provided, two staff were pulled to TMA (there was no TMA category on the staff posting), two staff were listed as orientation.<br><br>On 10/20/17, one RN, one LPN, one NA called in for the day shift. The staff posting was not updated and did not match the actual staffing schedule. A medication error occurred on the day shift on 2 South.<br><br>On 10/27/17, at 9:28 a.m. the director of nursing (DON) and staffing Coordinator were interviewed. The staffing pattern for the facility was determined by census and then by direction of the DON for each unit according to census. DON was aware that the current staffing may contribute to the quality of care and quality of life concerns identified during the survey and by substantiated complaints. Stated "I know it takes a little longer when staffing concerns, if call in nurses then nurse managers help more, all go help with breakfast and lunch meals." When asked if staff had brought concerns about workloads the DON replied "it comes up periodically, depends on the groups when bring to managers to redo groups, sometimes yah, I mean it depends." The DON did not elaborate further. | F 356 | | |
| F 431 SS=E | DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br>CFR(s): 483.45(b)(2)(3)(g)(h)<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State | F 431 | | 12/6/17 |

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| F 431 | Continued From page 49<br>law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>(h) Storage of Drugs and Biologicals.<br>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>(2) The facility must provide separately locked, permanently affixed compartments for storage of | F 431 | | |

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| F 431 | Continued From page 50<br>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 4 of 20 residents (R221, R15, R127, R57) who received Lantus (a long acting insulin used for the treatment of elevated blood sugars) did not receive expired medication and 1 of 8 residents (R57) who received NovoLog (a short acting insulin for the treatment of elevated blood sugars) did not receive expired medication.<br><br>Findings include:<br><br>R221's five-day Minimum Data Set (MDS) dated 9/14/17, indicated R221 was cognitively intact, received insulin injections seven days a week and had a diagnosis of diabetes mellitus (a disease where blood sugars are too high) with polyneuropathy (nerve damage related to diabetes).<br><br>During medication administration observation on 10/23/17, at 7:12 p.m. licensed practical nurse (LPN)-C prepared R221's Lantus 22 unit. The vial of Lantus was dated as opened 9/18/17. Prior to LPN-C entering R221's room surveyor stopped LPN-C and had him check the expiration date on the vial. LPN-C verified the Lantus was expired 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 | F 431 | 1. The identified expired insulins were removed from the med carts as soon as notified about the concern during the annual survey.<br>2. 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.<br>3. All other residents with an order for Insulin have had their insulin checked for expiration dates.<br>4. Licensed Nurses will be in-serviced on medication administration and storage<br>5. Licensed Nurses have been assigned education on medication administration and Diabetes through Health Care Academy to be completed by 12/6/17.<br>6. PharMerica Nurse Consultant will conduct a medication administration and storage audit on 11/28/17 and 11/29/17.<br>7. All Nurses will complete a medication storage self competency each shift they work until the next QAPI meeting 12/19/17.<br>8. Nursing leadership will complete Medication administration competency assessments on 5 Nurses per week until | |

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| F 431 | Continued From page 51<br>destroyed on 10/15/17.<br><br>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 101mg/dl-207mg/dl during the period of time from 10/16 through 10/23/17.<br><br>R15's quarterly MDS dated 9/9/17, indicated R15 was moderately independent with decision making, received insulin injections seven days a week and had a diagnosis of diabetes mellitus.<br><br>During medication cart observation on 10/23/17, at 7:21 p.m. Lantus vial for R15 was observed with a date open of 9/22/17. LPN-D verified the vial had been dated as opened 9/22/17, and stated Lantus was only good for 28 days. R15 stated R15 had received Lantus that day. Twenty-eight days from 9/22/17, was 10/19/17.<br><br>R15's October 2017 Medication Administration Records revealed R15 had an order dated 9/26/17, for Lantus 12 units daily. R15 received Lantus 20 units from 10/1/17, through 10/23/17. R15 received Lantus from an expired vial for four days. R15's blood sugars varied from 124mg/dl-278 mg/dl during the period of time from 10/19/ through 10/23/17.<br><br>R127's 30 day MDS dated 10/5/17, indicated R127 was cognitively intact, received insulin | F 431 | all Nurses have been assessed.<br>9. Nursing leadership will complete 5 medication storage competency audits weekly until the next QAPI meeting 12/19/17.<br>10. The facility QAPI committee will review completed audits and medication error reports monthly and make further recommendations.<br>11. See also F333.<br>12. The Director of Nursing remains responsible for compliance with this requirement to ensure that pharmaceutical services are provided to meet the needs of each resident. | |

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| F 431 | Continued From page 52<br>injections seven days a week and had a diagnosis of diabetes mellitus.<br><br>During medication cart observation on 10/23/17, at 7:24 p.m. Lantus vial for R127 was observed with a sticker on it that indicated date open of 9/17/17, and expiration date of 10/15/17. Registered nurse (RN)-G stated R127 was currently in the hospital and had been admitted to the hospital on 10/28/17. RN-G verified date on Lantus vial indicated it had been opened 9/17/17, and stated Lantus was only good for 28 days.<br><br>R127's October 2017 Medication Administration Records revealed R127 had an order dated 10/9/17, for Lantus 20 units daily. R127 had received Lantus 20 units from 10/11-10/19/17. R127 received Lantus from an expired vial for four days after it expired.<br><br>R127 Occurrence report closed 10/25/17, indicated R127's Lantus vial was opened 9/17/17, and should have been discarded 10/15/17.<br><br>R57's quarterly MDS dated 9/20/17, indicated R57 was severely cognitively impaired received insulin injections seven days a week and had a diagnosis of diabetes mellitus.<br><br>During medication cart observation on 10/24/17, at 9:46 a.m. Lantus vial for R57 was observed with a sticker on it that indicated date open of 9/21/17, LPN-E verified R57 received Lantus that morning. LPN-E stated she had given the Lantus and for some reason had not checked the date the Lantus vial was opened. LPN-E stated the vial should have been disposed of on 10/18/17. LPN-E verified R57 had a vial of NovoLog in the | F 431 | | |

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| F 431 | Continued From page 53 | F 431 | | |

medication cart dated opened 9/21/17 which should have been disposed of at the end of the day on 10/18/17. LPN-E stated R57 had not received NovoLog that day. LPN-E stated an expired medication that was given would be a medication error.

During interview on 10/24/17, at 10:01 a.m. RN-D stated giving expired insulin would be a medication error.

R57's October 2017 Medication Administration Records revealed R57 had an order dated 8/3/17, for Lantus 20 units daily. R57 had received Lantus 20 units from 10/1/17, through 10/24/17. R57 received Lantus from an expired vial for six days after it expired. R57's October Medication Administration Records revealed R57 had an order dated 9/18/17, for Novolog insulin three times a day based on blood sugars greater than 249 mg/dl. R57 had received six doses of Novolog insulin after 10/18/17.

During interview on 10/24/17, at 1:04 p.m. facility Medical Director giving a resident expired insulin would be a medication error.

During interview on 10/26/17, at 2:32 p.m. the director of nurses (DON) stated she would have expected the nurses to check the date open for any vial of insulin and if expired the nurses would not give the expired insulin. The DON stated Lantus and NovoLog are only good for 28 days from the time they were removed from the fridge or when they were opened. The DON stated giving expired insulin would be a medication error.

Food and Drug Administration Novolog drug

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| F 431 | Continued From page 54<br>insert NDA 20-986/S-032 dated 2006, indicated "NovoLog in unopened vials, cartridges, and NovoLog FlexPen Prefilled syringes should be stored between 2° and 8℃ (36° to 46℉). Do not freeze. Do not use NovoLog if it has been frozen or exposed to temperatures that exceed 37℃ (98.6℉). After a vial, cartridge, or Prefilled syringe has been punctured, it may be kept at temperatures below 30℃ (86℉) for up to 28 days, but should not be exposed to excessive heat or sunlight."<br><br>Sanofi-aventis Lantus medication insert revised 8/2015, indicated Lantus could be stored for 28 days at room temperature if the vial was opened or unopened.<br><br>Facility policy Storage of Medication dated 5/16, instructed staff, "12. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in refrigerator or at room temperature... 14. Outdated, contaminated, discontinued or deteriorated medications and those that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal..." | F 431 | | |
| F 441 SS=E | INFECTION CONTROL, PREVENT SPREAD, LINENS<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | F 441 | | 12/6/17 |

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| F 441 | Continued From page 55<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility | F 441 | | |

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| F 441 | Continued From page 56<br>must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure hand hygiene was maintained during cares for 1 of 4 residents (R150) observed during personal cares. In addition, the facility failed to ensure EZ Stand (mechanical standing lift) was cleaned between residents for whom the lift was used to assist with personal cares and to ensure it was not stored in the restroom next to the garden court dayroom. This had the potential to affect all 5 residents on Garden court who utilized the EZ lift.<br><br>Findings include:<br><br>R150 was observed on 10/25/17, at 1:38 p.m. Nursing assistant (NA)-B took R150 to the bathroom and attached the EZ stand lift (mechanical standing lift) harness around R150's | F 441 | F441<br>Infection Control<br><br>1. The facility Infection Control policy and procedures has been reviewed<br>2. Staff will be in-serviced on Infection Control (hand washing and glove use) and cleaning of mechanical lifts using specific 2567 survey examples.<br>3. The nursing leadership will complete hand washing and gloving competencies on 5 nursing staff per week until all staff have been completed.<br>4. The mechanical lifts will be audited weekly to ensure PDI wipes are in place.<br>5. The Director of Nursing will review completed audits and bring any identified concerns to the facility QAPI committee | |

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| **ST ANTHONY HEALTH & REHABILITATION** | **3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421** |

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| F 441 | Continued From page 57 waist. After registered Nurse (RN)-C arrived, NA-B washed hands and put on gloves. NA-B stood R150 utilizing the mechanical lift in the bathroom. There were two large wet spots on the back of the resident's pants. NA-B pulled R150 pants down and removed incontinence brief. R150 had saturated the incontinence pad and had soft brown stool coming out of her rectum. NA-B wiped the stool away and sat resident on the toilet. NA-B removed gloves washed hands and obtained clean pants for R150. NA-B put gloves on and removed R150's soiled pants which were wet and had stool on them and put them on the floor by the bathroom door. Without changing gloves or washing hands, NA-B put clean pants on R150. When R150 was done on the toilet, NA-B used EZ stand lift hand controls to stand R150 up. With the same pair of gloves NA-B washed R150's bottom, which had brown stool on it. There was also brown stool on the toilet seat. NA-B put a clean incontinence product on R150 and pulled R150's pants up. NA-B removed gloves and without washing her hands, adjusted the EZ stand harness around R150's waist. RN-C positioned R150's wheelchair under her and NA-B moved EZ stand closer to chair and lowered R150 into R150's Broda chair. Chair had not been wiped out even though R150's pants had evidence that urine had leaked through to the cushion. RN-C removed gloves and washed hands before taking R150 out to the television lounge. NA-B removed EZ stand from Bathroom and put it against the wall outside, the bathroom. NA-B washed hands and then picked R150's loose soiled clothing up off the floor with bare hands and took it to the soiled utility room. NA-B returned to the bathroom and put gloves on wiped the toilet seat of and then sanitized the toilet seat. NA-B removed gloves and washed hands. | F 441 | for further recommendations.<br>6. The Director of Nursing remains responsible for compliance with this requirement to ensure a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. | |

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R150's quarterly Minimum Data Set (MDS) dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all activities of daily living (ADLs) and R150 was frequently incontinent of bladder and bowel.

R83 was observed on 10/25/17, at 1:57 p.m. NA-B and RN-D took R83 to the bathroom. NA-B brought in the EZ stand lift, which had not been wiped down after it was used for R150. NA-B and RN-D washed hands and put on gloves. NA-B and RN-D put same harness that had been used for R150 on R83 and stood R83 up. NA-B stood R83 up pulled down pants and removed R83's wet incontinence pad. NA-B preformed incontinence cares and was cued by RN-D to change gloves and wash hands prior to putting a clean incontinence product on R83. NA-B pulled R83's pants up and helped R83 to sit in the wheelchair. RN-D and NA-B removed gloves and washed hands. RN-D assisted R83 to hash hands and then took resident out of the bathroom to the dining room. The EZ stand was left in the bathroom. The EZ stand was not wiped down after usage.

R83's annual MDS dated, 9/20/17, indicated R83 had dementia, and could not complete the cognitive portion of the MDS. The MDS further noted R83 was an extensive assist with all ADLs and R83 was frequently incontinent of bladder and bowel.

On 10/25/17, at 2:05 p.m. R97 walked into the bathroom. EZ stand which had not been wiped

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down was still in the bathroom. Two unknown staff members followed R97 into the bathroom and shut the door. The EZ stand remained in the bathroom.

R97's quarterly MDS dated 7/19/17, indicated R97 had dementia and was severely cognitively impaired. The MDS further noted R97 was an extensive assist with all activities of daily living (ADLs) and R97 was frequently incontinent of bladder and bowel.

During interview on 10/25/17, at 2:07 p.m. NA-B stated she usually would wash her hands after removing gloves but was nervous and must have forgotten. NA-B verified she wiped down the toilet but did not wipe down the EZ stand. NA-B stated staff would wipe down the EZ stand a couple of times during the shift. NA-B verified she did not wipe down the EZ stand between residents.

During interview on 10/25/17, at 2:22 p.m. RN-C verified NA-B did not change gloves after doing pericare for R150 before putting a clean incontinence product on or doing any other cares. RN-C stated NA-B should have washed her hands after removing gloves and before touching resident or the machine. RN-C stated NA-B should have worn gloves, and put the soiled clothing into a bag before taking them to the soiled utility room.

During interview on 10/25/17, at 2:49 p.m. RN-D stated would expect after pericare, staff would remove gloves and wash their hands. RN-D stated the lifts are to be wiped down after every use.

During interview on 10/26/17, at 2:32 p.m. the

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| F 441 | Continued From page 60<br>director of nursing (DON), stated staff were to remove gloves and wash hands after providing pericare. The DON stated it was not appropriate to touch a resident's clothing, a mechanical lift or lift belt after removing gloves if hands had not been washed. The DON stated that mechanical lifts were to be wiped down with sanitizer after every resident use and daily by housekeeping.<br><br>Mechanical lift cleaning policy requested but not provided.<br><br>Hand Hygiene policy approved 10/6/17, instructs staff, "1. hand hygiene requirements: Before and after contact with residents. c. After contact with contaminated environmental surfaces adjacent to the resident... e. After toileting or assisting residents with toileting, handling of urinals, bedpans, catheters, soiled linens, towels wash cloths....i. Before performing a resident care ADL procedure and after removal of gloves if worn....m. After contact with blood, urine feces, oral secretions, mucous membranes or broken skin." | F 441 | | |
| F 465<br>SS=E | SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>CFR(s): 483.90(i)(5)<br><br>(i) Other Environmental Conditions<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account | F 465 | | 12/6/17 |

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| F 465 | Continued From page 61<br>non-smoking residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure a sanitary environment for 10 of 11 residents (R271, R110, R40, R26, R14, R45, R267, R191, R34, R45).<br><br>Findings include:<br><br>R271 was admitted 12/3/16, and discharged back to hospital by 911 on 4/3/17 per the Face Sheet. The admission diagnoses include Parkinson's disease, dementia, dysphagia (inability to swallow food safely) with feeding tube for nutrition, unable to communicate, history of heart bypass and kidney cancer with urine retention and suprapubic Foley catheter. R271 required extensive assistance with bed mobility, transfers, and toilet use; was totally dependent on staff for dressing and eating (tube feeding). On 4/3/17, R271's spouse complained of feces and urine on toilet seat, and unclean room.<br><br>R110 had an annual Minimum Data Set (MDS) assessment on 8/11/17, had moderate cognitive impairment, and did not reject cares, and needed extensive assistance of two staff for bed mobility, transfers and toilet use. On 10/24/17, at 9:07 a.m. R110's call light was very hard to press to activate the light. R110's room had paint off the entire length of the wall heat register. R110's wheelchair armrests were missing the vinyl covering which made the wheelchair uncleanable.<br><br>R40 quarterly MDS review dated 7/25/17, indicated R40 was cognitively intact, had moderately severe depression, and was independent with supervision for cares. On | F 465 | F465<br>Safe/Functional/Sanitary/Comfortable Environment<br><br>1. 10 out of 10 resident environmental concerns were immediately addressed.<br>2. Each resident room and resident bathroom in the facility was reviewed for cleanliness.<br>3. Each resident wheelchair was reviewed for cleanliness and repair.<br>4. Each resident grab bar was reviewed to ensure material is intact.<br>5. Each resident call light has been audited for function and placement.<br>6. Each resident room has been checked for extra cable boxes.<br>7. Housekeeping policies were reviewed and all Housekeeping staff were re-educated on proper cleaning techniques.<br>8. The housekeeping and maintenance department will conduct environmental audits of items #2-#5 weekly until the next facility QAPI meeting on 12/19/2017.<br>9. The facility QAPI committee will review completed audit results and make further recommendations.<br>10. The Executive Director remains responsible for compliance with this requirement, to ensure that residents are provided a safe, functional, sanitary, and comfortable environment. | |

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| F 465 | Continued From page 62<br>10/24/17, at 9:10 a.m. R40's wheelchair armrests were tattered, with vinyl missing making it an uncleanable surface. In addition, the wheelchair cushion remained uncleaned. R40's call light was detached from the wall. When he needed help he would stand up, reach over the rolling tray table with multiple beverages and items on it, blocking the way to the call light on the wall. At 10:00 a.m. on 10/24/17, registered nurse (RN)-H stated aides should be checking for working call lights.<br><br>R40's room was observed on 10/24/17, at 10:53 a.m. R40's the surfaces of both the manual wheelchair arm rests were cracked and areas of white padding were clearly visible. More areas of padding were exposed on front of both armrests and appeared to be soiled with a light brown substance.<br><br>During a tour on 10/26/17, at 1:39 p.m. the acting maintenance director and the housekeeping director said surface of the armrests could not be cleaned.<br><br>R26's annual assessment dated 9/22/17, indicated R27 had severely impaired cognition, and needed extensive assistance of two staff for bed mobility, transfers and toilet use. On10/23/17, at 4:19 p.m. R26's call light was trapped under mattress. R26 was unable to reach it. R26 stated she can use it to get staff. On 10/23/17, at 4:19 p.m. licensed practical nurse (LPN)-C came into room as requested and put the call light close to R26.<br><br>R14 was admitted 9/25/17, per the Face Sheet. On 10/24/17, at 9:50 a.m. R14 stated the sink was not kept clean in the bathroom. Staff clean the sink, but it gets dirty fast and "I cannot use the | F 465 | | |

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sink when it's dirty because of my colostomy." There was missing grout around the base of heater.

R45's quarterly MDS review dated 8/25/17, indicated R45 was cognitively intact, needed extensive assistance of two staff for bed mobility, transfers and toilet use. On 10/23/17, at 7:47 p.m. the grab bars on the bed had foam peeling off and were no longer a cleanable surface.

R267 was admitted to the facility on 10/11/17, per the Face Sheet. On 10/24/2017, at 11:07 a.m. R267 stated sometimes the bathroom was not clean, "like today I walked in there and it wasn't clean, I told staff and housekeeping came had to come in and clean it."

R191's re-admission MDS assessment dated 9/12/17, indicated R191 was cognitively intact with minimal depression, and needed extensive assistance of two staff for bed mobility, transfers and toilet use. On 10/24/17, at 1:08 p.m. there was a medium sized brown stain on grout of toilet base.

R34's quarterly review MDS dated 9/29/17, indicated R34 was cognitively intact with minimal depression, and needed limited assistance of one staff for bed mobility, transfers and toilet use.

R34's room was observed on 10/23/17, at approximately 7:00 p.m. R34's room was observed to contain a cable internet box hanging by two cables approximately six inches out of the wall, about two feet to the right of the head of R34's bed, between the headboard and the window.

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R34 was interviewed at the time of the observation and said some man had left it there and it had been there for months. R34 said the man had given her a television remote. R34 picked up the remote from her bedside stand, still wrapped in plastic.

A printed email communications dated 5/12/17, from the maintenance director to the facility administrator indicated cable instillation was to take place on May 12, 2017.

R45's room was observed on 10/23/17, at approximately 7:00 p.m., R45's bed right side grab bar was observed to have foam on the top of the bar that was ripped, with approximately three inches missing.

During a tour on 10/26/17, at 1:39 p.m. the acting maintenance director and the housekeeping director said surface of the grab bar could not be cleaned.

2 North Unit:
On 10/23/17, at approximately 7:00 p.m., the ceiling vents near the fire door on 2 North unit were noted to have a fine gray substance on the surfaces of all of the grates in each vent. The same substance was noted on the ceiling tiles touching the ceiling vents.

During an interview on 10/25/17, at 2:18 p.m., the housekeeping director said the housekeeping staff should have cleaned the ceiling vents. The housekeeping director said a member of the housekeeping staff should have notified the maintenance department about the wheelchair

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arms, the damaged side rail and the cable box hanging from the wall. The housekeeping director said the housekeeping staff inspected resident areas as part of their daily cleaning schedule and were instructed to call the maintenance department if a concern was identified and leave a voicemail message on the Maintenance Connection line to initiate maintenance work order.

During an interview on 10/25/17, at 10:53 a.m., the acting director of maintenance said she checked the Maintenance Connect line daily and compiled a list of work orders. She said the work orders were stored in this list until completed. A list or work orders was provided, with work orders dating back three months.

During an interview with the administrator on 10/26/17, at 9:31 a.m., she said she expected the maintenance department to prioritize the work orders. After reviewing the current list of work orders, the facility administrator said she was surprised by the number of unfinished work orders and said she questioned about how the work orders been prioritized.

The Maintenance Work Order/Repair Requisition policy and Procedure last reviewed on 8/09 instructed any employee to call and report environmental risks and to request service.

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

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

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

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

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

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

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

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

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

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **ST ANTHONY HEALTH & REHABILITATION** | **3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421** |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>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.<br><br>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.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. | 2 000 | | |

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| 2 000 | Continued From page 2<br>THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.<br><br>An investigation of complaints H5267080 and H5267081 were completed at the time of the survey. Complaint H5267080 was not substantiated. Compliant H5267081 was substantiated at §144.651 Subd. 15, and §626.557 Subd. 17 (A-C). | 2 000 | | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 3 resident (R29) reviewed for urinary incontinence.<br><br>Findings include:<br><br>R29's face sheet dated 10/2013, indicated current diagnoses of dementia without behavioral disturbance and osteoarthritis. R29's annual Minimum Data Set (MDS) dated 8/23/17, indicated absence of spoken words regarding speech clarity and severely impaired cognition. | 2 565 | 1. Resident R29 s care plans and NAR sheets reviewed and revised as needed to reflect current bladder incontinence status.<br>2. Other residents will have their Toileting care plans updated with each quarterly, annual, or significant change of condition MDS.<br>3. Staff will be in-serviced on following care plan interventions/NAR assignment sheets and toileting schedules using specific survey findings as an example.<br>4. Nursing leadership will complete toileting competencies on 8 staff per week | 12/6/17 |

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| 2 565 | Continued From page 3<br>R29 required extensive assist of one person to transfer to or from bed, chair, wheelchair and one person extensive assist for toilet use including cleansing self after elimination and pad changes. R29's care area assessment (CAA) for communication, dated 9/1/17, indicated resident is never/rarely understood verbally and resident does not speak and is deaf. CAA for urinary incontinence and indwelling catheter indicated R29 was frequently incontinent, required extensive assist of one staff for toileting and was not able to manage incontinence, change her pads, or take care of own pericares.<br><br>R29's care plan, effective date 10/30/17, to present, indicated resident's alteration in bowel and bladder function due to dementia, frequent incontinence of bowel and bladder directed facility staff to offer toileting upon rising, before/after meals, HS (at bedtime), NOC (at night) rounds and PRN (as needed) AX1 (assist times 1). AX1 with pad change and pericare after incontinence every shift.<br><br>Garden Court NAR Report Sheet, not dated, indicated R29 was incontinent of bowel and bladder, was to offer toileting upon rising, before/after meals, HS, NOC rounds and PRN AX1.<br><br>During continuous observation on 10/25/17, at 7:18 a.m. to 10:29 a.m., for incontinence care:<br>-At 7:18 a.m., R29 was brought into Garden Court dining room via wheel chair.<br>-From 8:08 a.m. to 8:58 a.m., R29 was observed eating breakfast with staff assist, then brought to Garden Court day room by staff.<br>-At 9:02 a.m., nursing assistant (NA)-A was observed to place the gait belt around the R29's waist, transferred R29 from wheelchair to day | 2 565 | until all NAR staff have been completed.<br>5. The facility QAPI committee will review completed toileting competency results and make further recommendations.<br>6. See also F312<br>7. The Director of Nursing remains responsible for compliance with this requirement, to ensure that services are provided in accordance with each resident s plan of care. | |

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| 2 565 | Continued From page 4 | 2 565 | | |

room chair.
-From 9:24 a.m. to 9:47 a.m., R29 observed with eyes closed in the day room.
-From 9:49 a.m. to 10:12 a.m., R29 was awake and observed watching television and interacting with staff.
-From 10:29 a.m. to 10:41 a.m., R29 continued to sit in day room chair.

During an interview on 10/25/17, at 10:41 a.m., when asked NA-B if R29 was offered or if incontinence care was done stated "I'll take her to the bathroom when I get back from break." NA-B further stated that R29 usually goes every three hours and does not void much and was usually dry when she took her to the bathroom. NA-B verified she had not taken R29 that morning, in reference to toileting R29. NA-B further stated that NA-A "felt to see if she was dry before she transferred her to the other chair, before she sat her down. You can usually tell if the pad is heavy."

During an interview on 10/25/17, at 10:55 a.m., when asked to describe how R29 was checked for incontinence NA-A indicated she "padded her bottom to make sure that she was dry" before resident was transferred to the regular chair in the day room.

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 and expected a pad check, prefer to check in private. 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. RN-D stated she would prefer to do a visual pad check in a private area.

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| 2 565 | Continued From page 5<br><br>During an interview with the director of nursing (DON) when asked if she would expect staff to check R29's incontinence pad in the day room, she stated "no, I expect them to do it in a private area."<br><br>Facility policy for following the care plan was requested, policy titled "Comprehensive Care Plans" was given.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 565 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced | 2 830 | | 12/6/17 |

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| 2 830 | Continued From page 6<br>by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 5 residents (R29) reviewed who was dependent on staff assistance with toileting, received care and services in a timely manner.<br><br>Findings include:<br><br>R29's face sheet dated 10/2013, indicated diagnoses including: dementia without behavioral disturbance and osteoarthritis. R29's annual Minimum Data Set (MDS) dated 8/23/17, indicated the resident had an absence of spoken words regarding speech clarity and had severely impaired cognition. R29 required extensive assist of one person to transfer to or from bed, chair, or wheelchair, and required extensive assist of one person for toilet use including cleansing self after elimination and pad changes. R29's care area assessment (CAA) for communication, dated 9/1/17, indicated the resident was never/rarely understood verbally, did not speak and was deaf. CAA for urinary incontinence and indwelling catheter indicated R29 was frequently incontinent, required extensive assist of one staff for toileting and was not able to manage incontinence, change her pads, or take care of own pericares.<br><br>R29's care plan, effective date 10/30/17, to present, indicated resident's alteration in bowel and bladder function due to dementia, frequent incontinence of bowel and bladder directed facility staff to offer toileting upon rising, before/after meals, HS (at bedtime), NOC (at night) rounds and PRN (as needed) AX1 (assist times 1). AX1 with pad change and pericare after incontinence every shift.<br><br>The Garden Court NA (nursing assistant) Report | 2 830 | 1. Resident R29 s care plans and NAR sheets reviewed and revised as needed to reflect current bladder incontinence status.<br>2. Other residents will have their Toileting care plans updated with each quarterly, annual, or significant change of condition MDS.<br>3. Staff will be in-serviced on following care plan interventions/NAR assignment sheets and toileting schedules using specific survey findings as an example.<br>4. Nursing leadership will complete toileting competencies on 8 staff per week until all NAR staff have been completed.<br>5. The facility QAPI committee will review completed toileting competency results and make further recommendations.<br>6. See also F282<br>7. The Director of Nursing remains responsible for compliance with this requirement, to ensure that residents receive the appropriate treatment and services to improve/maintain ADLS. | |

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| 2 830 | Continued From page 7 | 2 830 | | |

Sheet, not dated, indicated R29 was incontinent of bowel and bladder, was to offer toileting upon rising, before/after meals, HS, NOC rounds and PRN AX1.

During continuous observation on 10/25/17, at 7:18 a.m. to 10:29 a.m., for incontinence care:
-At 7:18 a.m., R29 was brought into Garden Court dining room via wheel chair.
-From 8:08 a.m. to 8:58 a.m., R29 was observed eating breakfast with staff assist, then brought to Garden Court day room by staff.
-At 9:02 a.m., nursing assistant (NA)-A was observed to place the gait belt around the R29's waist, transferred R29 from wheelchair to day room chair.
-From 9:24 a.m. to 9:47 a.m., R29 observed with eyes closed in the day room.
-From 9:49 a.m. to 10:12 a.m., R29 was awake and observed watching television and interacting with staff.
-From 10:29 a.m. to 10:41 a.m., R29 continued to sit in day room chair.

During an interview on 10/25/17, at 10:41 a.m., when asked NA-B if R29 was offered or if incontinence care was done stated "I'll take her to the bathroom when I get back from break." NA-B further stated that R29 usually goes every three hours and does not void much and was usually dry when she took her to the bathroom. NA-B verified she had not taken R29 that morning, in reference to toileting R29. NA-B further stated that NA-A "felt to see if she was dry before she transferred her to the other chair, before she sat her down. You can usually tell if the pad is heavy."

During an interview on 10/25/17, at 10:55 a.m., when asked to describe how R29 was checked for incontinence NA-A indicated she "padded her

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| 2 830 | 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.

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 services are implemented.

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

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| 21375 | Continued From page 9 | 21375 | | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program<br><br>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure hand hygiene was maintained during cares for 1 of 4 residents (R150) observed during personal cares. In addition, the facility failed to ensure EZ Stand (mechanical standing lift) was cleaned between residents for whom the lift was used to assist with personal cares and to ensure it was not stored in the restroom next to the garden court dayroom. This had the potential to affect all residents on Garden court.<br><br>Findings include:<br><br>During observation on 10/25/17, at 1:38 p.m. nursing assistant (NA)-B took R150 to the bathroom and attached the EZ stand lift (mechanical standing lift) harness around R150's waist. After registered Nurse (RN)- C arrived, NA-B washed hands and put on gloves. NA-B stood R150 utilizing the mechanical lift in the bathroom. There were two large wet spots on the back of the resident's pants. NA-B pulled R150 pants down and removed incontinence brief. R150 had saturated the incontinence pad and had soft brown stool coming out of her rectum. NA-B wiped the stool away and sat resident on the toilet. NA-B removed gloves washed hands and obtained clean pants for R150. NA-B put | 21375 | 1. The facility Infection Control policy and procedures has been reviewed<br>2. Staff will be in-serviced on Infection Control (hand washing and glove use) and cleaning of mechanical lifts using specific 2567 survey examples.<br>3. The nursing leadership will complete hand washing and gloving competencies on 5 nursing staff per week until all staff have been completed.<br>4. The mechanical lifts will be audited weekly to ensure PDI wipes are in place.<br>5. The Director of Nursing will review completed audits and bring any identified concerns to the facility QAPI committee for further recommendations.<br>6. The Director of Nursing remains responsible for compliance with this requirement to ensure a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. | 12/6/17 |

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| 21375 | Continued From page 10 | 21375 | | |

gloves on and removed R150's soiled pants which were wet and had stool on them and put them on the floor by the bathroom door. Without changing gloves or washing hands, NA-B put clean pants on R150. When R150 was done on the toilet, NA-B used EZ stand lift hand controls to stand R150 up. With the same pair of gloves NA-B washed R150's bottom, which had brown stool on it. There was also brown stool on the toilet seat. NA-B put a clean incontinence product on R150 and pulled R150's pants up. NA-B removed gloves and without washing her hands, adjusted the EZ stand harness around R150's waist. RN-C positioned R150's wheelchair under her and NA-B moved EZ stand closer to chair and lowered R150 into R150's Broda chair. Chair had not been wiped out even though R150's pants had evidence that urine had leaked through to the cushion. RN-C removed gloves and washed hands before taking R150 out to the television lounge. NA-B removed EZ stand from Bathroom and put it against the wall outside, the bathroom. NA-B washed hands and then picked R150's loose soiled clothing up off the floor with bare hands and took it to the soiled utility room. NA-B returned to the bathroom and put gloves on wiped the toilet seat of and then sanitized the toilet seat. NA-B removed gloves and washed hands.

R150's quarterly Minimum Data Set (MDS) dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all activities of daily living (ADLs) and R150 was frequently incontinent of bladder and bowel.

R83
On 10/25/17, at 1:57 p.m. NA-B and RN-D took R83 to the bathroom. NA-B brought in the EZ

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stand lift, which had not been wiped down after it was used for R150. NA-B and RN-D washed hands and put on gloves. NA-B and RN-D put same harness that had been used for R150 on R83 and stood R83 up. NA-B stood R83 up pulled down pants and removed R83's wet incontinence pad. NA-B preformed incontinence cares and was cued by RN-D to change gloves and wash hands prior to putting a clean incontinence product on R83. NA-B pulled R83's pants up and helped R83 to sit in the wheelchair. RN-D and NA-B removed gloves and washed hands. RN-D assisted R83 to hash hands and then took resident out of the bathroom to the dining room. The EZ stand was left in the bathroom. The EZ stand was not wiped down after usage.

R83's annual MDS dated, 9/20/17, indicated R83 had dementia, and could not complete the cognitive portion of the MDS. The MDS further noted R83 was an extensive assist with all ADLs and R83 was frequently incontinent of bladder and bowel.

On 10/25/17 at 2:05 p.m. R97 walked into the bathroom. EZ stand which had not been wiped down was still in the bathroom. Two unknown staff members followed R97 into the bathroom and shut the door. The EZ stand remained in the bathroom.

R97's quarterly MDS dated 7/19/17, indicated R97 had dementia and was severely cognitively impaired. The MDS further noted R97 was an extensive assist with all activities of daily living (ADLs) and R97 was frequently incontinent of bladder and bowel.

During interview on 10/25/17, at 2:07 p.m. NA-B

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stated she usually would wash her hands after removing gloves but was nervous and must have forgotten. NA-B verified she wiped down the toilet but did not wipe down the EZ stand. NA-B stated staff would wipe down the EZ stand a couple of times during the shift. NA-B verified she did not wipe down the EZ stand between residents.

During interview on 10/25/17, at 2:22 p.m. RN-C verified NA-B did not change gloves after doing pericare for R150 before putting a clean incontinence product on or doing any other cares. RN-C stated NA-B should have washed her hands after removing gloves and before touching resident or the machine. RN-C stated NA-B should have worn gloves, and put the soiled clothing into a bag before taking them to the soiled utility room.

During interview on 10/25/17, at 2:49 p.m. RN-D stated would expect after pericare, staff would remove gloves and wash their hands. RN-D stated the lifts are to be wiped down after every use.

During interview on 10/26/17, at 2:32 p.m. the director of nursing (DON), stated staff were to remove gloves and wash hands after providing pericare. The DON stated it was not appropriate to touch a resident's clothing, a mechanical lift or lift belt after removing gloves if hands had not been washed. The DON stated that mechanical lifts were to be wiped down with sanitizer after every resident use and daily by housekeeping.

Mechanical lift cleaning policy requested but not provided.

Hand Hygiene policy approved 10/6/17, instructs staff, "1. hand hygiene requirements: Before and

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| 21375 | Continued From page 13<br>after contact with residents. c. After contact with contaminated environmental surfaces adjacent to the resident... e. After toileting or assisting residents with toileting, handling of urinals, bedpans, catheters, soiled linens, towels wash cloths....i. Before performing a resident care ADL procedure and after removal of gloves if worn....m. After contact with blood, urine feces, oral secretions, mucous membranes or broken skin."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on the appropriate cleaning of multiple patient use equipment to prevent cross contamination and then monitor for compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 21375 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must | 21426 | | 11/17/17 |

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| 21426 | Continued From page 14<br>be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure tuberculosis (TB) symptom screening was completed for 1 of 5 residents (R27) who was recently admitted to the facility. In addition, the facility failed to ensure 1 of 5 employees (E1) tuberculosis screening (chest x-ray) had medical doctor (MD) interpretation of results to rule out active tuberculosis.<br><br>Findings include:<br><br>R27 was admitted to the facility on 8/24/17. There was no evidence in the medical record of a baseline TB symptoms screening prior to TST testing. R27 received the first tuberculin skin test (TST) on 8/24/17, with results read on 8/26/17, as negative, 0 mm of induration. R27 received the second TST on 9/4/17, with results read on 9/6/17, as negative, 0 mm of induration. A TB symptom screen was completed on 9/7/17, three days after the second TST.<br><br>During interview on 10/27/17, at 7:40 a.m. the director of nursing (DON) verified the TB symptom screen was not and should have been completed prior to the first step TST.<br><br>During interview on 10/27/17, at 9:22 a.m. registered nurse (RN)-B verified a TB symptom screen was completed on 9/7/17, after the second TST, but should have been completed | 21426 | MN Rule 144A.04<br>TB screening<br><br>Residents<br><br>1. TB screening tool was completed for R27 on 9/7/17.<br>2. All other residents have had a TB screening completed.<br>3. Licensed Nurses will be re-educated on the TB screening tool.<br>4. Nursing leadership will audit new admissions for completion of the TB screening tool.<br>5. The Director of Nursing will review completed audits and bring any identified concerns to the facility QAPI committee for further recommendations.<br>6. The Director of Nursing remains responsible to ensure new admissions are screened for TB.<br><br>Staff<br><br>1. Employee E1 has a new chest x-ray scheduled for 11/21/2017.<br>2. All other new employees hired in past 6 months have been reviewed to ensure TB screening has been completed<br>3. The facility has contracted with Mobilex to complete all pre-employment employee | |

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| 21426 | Continued From page 15<br>prior to the first TST.<br><br>E-1's hire date was 9/13/17. A TB symptom screen was completed 9/13/17. A medical visit on 8/17/17, for E-1 indicated "XR [X-ray] CHEST AP [x-rays pass from front-to-back] or PA LATERAL [x-rays pass from back-to-front] and Throat Rapid Strep - BMC," were completed. The report indicated "Chest x-ray was normal." There was no indication E-1 received a medical evaluation to rule out active tuberculosis.<br><br>During interview on 10/27/17, at 9:22 a.m. RN-B stated she was not sure if E1's chest x-ray was completed to rule out active TB and verified there was not a MD evaluation.<br><br>Review of the facility TB resident screening dated 8/31/15, indicated all residents must be screened upon admission with a 2 step PPD (purified protein derivative) Mantoux test or have proof of testing (documentation of a chest x-ray that shows free from active pulmonary TB disease or written documentation of a negative two-step Mantoux PPD (purified protein derivative) obtained within 90 days prior to admission). The policy lacked direction on conducting a TB symptom screen.<br><br>Review of the facility TB screening dated 1/1/16, indicated all employees must document that they do not have TB before providing direct contact with clients. The facility indicated that if the person has had a documented history of a positive Mantoux, written documentation that indicates negative results of a chest radiograph and an assessment for current TB symptoms will be completed. | 21426 | chest x-rays for the facility.<br>4. The hiring managers have been educated on pre-employment TB screening.<br>5. The facility HR manager will audit all new employee files for appropriate TB screening.<br>6. The Executive Director remains responsible to ensure all new employees are screened for TB. | |

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| 21426 | Continued From page 16<br><br>SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure tuberculin screening procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21426 | | |
| 21495 | MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services<br><br>Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide adequate assessment and services for 1 of 1 resident (R186) diagnosed with mental illness symptoms affecting activities of daily living (ADL) regarding poor appetite.<br><br>Findings include:<br><br>R186's admission note dated 5/19/15, by the certified nurse practitioner (CNP), indicated R186 weighed 68.5 pounds and had a BMI (body mass index) of 11.8.<br><br>R186's admission diagnoses report dated 5/28/15, included diagnoses of bipolar disorder | 21495 | 1. R186 was immediately offered psychology services, and refused. SS to continue to offer psychology services to resident at each care conference and PRN.<br>2. All residents in the building were reviewed for appropriate of psychology services, and assessed by psychology as desired by resident.<br>3. The facility has developed a psychology referral procedure.<br>4. Social Service staff educated on the psychology referral procedure.<br>5. All staff has been assigned the course mental health needs of the older adult in HCA for the month of December. | 12/6/17 |

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| 21495 | Continued From page 17<br>(mental illness that causes shifts in ability to think clearly) and anorexia (an eating disorder characterized by self-starvation).<br><br>R186's care plan, effective 5/29/15 to current, indicated R186 had inadequate food intake related to poor appetite and instructed staff to encourage oral intake and intervene when appropriate.<br><br>R186's clinical note from the facility social worker dated 1/9/17, indicated R186 had a poor appetite and social services would monitor and follow up as needed.<br><br>R186's ADL verification worksheets dated 8/31/17 through 10/25/17, indicated R186 consumed ate a small percentage of one to two meals per day.<br><br>The Care Conference note dated 10/5/17, indicated R186 refused dietary supplements and had a poor intake at meal time.<br><br>On 10/26/17, R186's weight was documented as 69.0 pounds. R186 weight loss needs were not followed up on per the social note of 1/9/17.<br><br>On 10/25/17, at 9:10 a.m., R186's treating physician was interviewed and said he did not remember writing an order for a psychiatric consultation and he thought social services took care of that.<br><br>During an interview on 10/25/17, at 10:32 a.m. registered nurse (RN)-F said the physician usually wrote an order for a psychiatric consult and R186 did not have an order for a consultation.<br><br>A clinical note dated 10/25/17, during the survey | 21495 | 6. All residents will continue to be reviewed for appropriate psychology services during every care conference.<br>7. The facility QAPI committee will review residents receiving psychology services and make further recommendations.<br>8. The Executive Director remains responsible for compliance with this requirement, to ensure that residents receive social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. | |

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process, at 12:08 p.m. indicated the facility social worker met with R186 and offered in-house psychology services.

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.

During an interview on 10/26/17, at 11:38 a.m., the facility dietician said she had not done an assessment of R186 nutrition, as she was new to the facility. The dietician stated R186 would have benefitted from a psychiatric consult to better understand why R186 was not eating. The current dietician could not find evidence in the medical record of a nutritional assessment being completed.

The facility policy titled mental health services dated 1/30/13, indicated social services will be notified by nursing staff of need for mental health intervention and nursing is to acquire a doctor's order and notify social services. It indicated social services will contact the contracted mental health provider for services.

SUGGESTED METHOD OF CORRECTION:
The DON could conduct a comprehensive assessment to determine the appropriate interventions to provide for residents with behavioral issues. A plan could be developed and revised so that behavioral interventions could be evaluated for effectiveness and revisions made. An ongoing audit that included all residents with behavioral issues could be reviewed at the quality review committee meetings.

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| 21495 | Continued From page 19<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21495 | | |
| 21545 | MN Rule 4658.1320 A.B.C Medication Errors<br><br>A nursing home must ensure that:<br>A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:<br>(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or<br>(2) the administration of expired medications.<br>B. It is free of any significant medication error. A significant medication error is:<br>(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or<br>(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br>C. All medications are administered as | 21545 | | 12/6/17 |

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| 21545 | Continued From page 20<br>prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure residents were free of significant medication errors for 4 of 20 residents (R221, R15, R127, R57) who received Lantus (a long acting insulin used for the treatment of elevated blood sugars), and for 1 of 8 residents (R57) who received NovoLog (a short acting insulin for the treatment of elevated blood sugars).<br><br>Findings include:<br><br>R221's five-day Minimum Data Set (MDS) dated 9/14/17, indicated R221 was cognitively intact, received insulin injections seven days a week and had a diagnosis of diabetes mellitus (a disease where blood sugars are too high) with polyneuropathy (nerve damage related to diabetes).<br><br>During medication administration observation on 10/23/17, at 7:12 p.m. licensed practical nurse (LPN)-C prepared R221's Lantus 22 unit. The vial of Lantus was dated as opened 9/18/17. Prior to LPN-C entering R221's room surveyor stopped LPN-C and had him check the expiration date on the vial. LPN-C verified the Lantus was expired | 21545 | 1. The identified expired insulins were removed from the med carts as soon as notified about the concern during the annual survey.<br>2. 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.<br>3. All other residents with an order for Insulin have had their insulin checked for expiration dates.<br>4. Licensed Nurses will be in-serviced on medication administration and storage<br>5. Licensed Nurses have been assigned education on medication administration and Diabetes through Health Care Academy to be completed by 12/6/17.<br>6. PharMerica Nurse Consultant will conduct a medication administration and storage audit on 11/28/17 and 11/29/17.<br>7. All Nurses will complete a medication storage self competency each shift they work until the next QAPI meeting 12/19/17. | |

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| 21545 | Continued From page 21<br>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.<br><br>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 101mg/dl-207mg/dl during the period of time from 10/16 through 10/23/17.<br><br>R15's quarterly MDS dated 9/9/17, indicated R15 was moderately independent with decision making, received insulin injections seven days a week and had a diagnosis of diabetes mellitus.<br><br>During medication cart observation on 10/23/17, at 7:21 p.m. Lantus vial for R15 was observed with a date open of 9/22/17. LPN-D verified the vial had been dated as opened 9/22/17, and stated Lantus was only good for 28 days. R15 stated R15 had received Lantus that day. Twenty-eight days from 9/22/17, was 10/19/17.<br><br>R15's October 2017 Medication Administration Records revealed R15 had an order dated 9/26/17, for Lantus 12 units daily. R15 received Lantus 20 units from 10/1/17, through 10/23/17. R15 received Lantus from an expired vial for four days. R15's blood sugars varied from 124mg/dl-278 mg/dl during the period of time from 10/19/ through 10/23/17. | 21545 | 8. Nursing leadership will complete Medication administration competency assessments on 5 Nurses per week until all Nurses have been assessed.<br>9. Nursing leadership will complete 5 medication storage competency audits weekly until the next QAPI meeting 12/19/17.<br>10. The facility QAPI committee will review completed audits and medication error reports monthly and make further recommendations.<br>11. See also F431.<br>12. The Director of Nursing remains responsible to ensure residents are free of any significant medication errors. | |

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| 21545 | Continued From page 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.

During medication cart observation on 10/23/17, at 7:24 p.m. Lantus vial for R127 was observed with a sticker on it that indicated date open of 9/17/17, and expiration date of 10/15/17. Registered nurse (RN)-G stated R127 was currently in the hospital and had been admitted to the hospital on 10/28/17. RN-G verified date on Lantus vial indicated it had been opened 9/17/17, and stated Lantus was only good for 28 days.

R127's October 2017 Medication Administration Records revealed R127 had an order dated 10/9/17, for Lantus 20 units daily. R127 had received Lantus 20 units from 10/11-10/19/17. R127 received Lantus from an expired vial for four days after it expired.

R127 Occurrence report closed 10/25/17, indicated R127's Lantus vial was opened 9/17/17, and should have been discarded 10/15/17.

R57's quarterly MDS dated 9/20/17, indicated R57 was severely cognitively impaired received insulin injections seven days a week and had a diagnosis of diabetes mellitus.

During medication cart observation on 10/24/17, at 9:46 a.m. Lantus vial for R57 was observed with a sticker on it that indicated date open of 9/21/17, LPN-E verified R57 received Lantus that morning. LPN-E stated she had given the Lantus and for some reason had not checked the date the Lantus vial was opened. LPN-E stated the vial should have been disposed of on 10/18/17.

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| 21545 | Continued From page 23 | 21545 | | |

LPN-E verified R57 had a vial of NovoLog in the medication cart dated opened 9/21/17 which should have been disposed of at the end of the day on 10/18/17. LPN-E stated R57 had not received NovoLog that day. LPN-E stated an expired medication that was given would be a medication error.

During interview on 10/24/17, at 10:01 a.m. RN-D stated giving expired insulin would be a medication error.

R57's October 2017 Medication Administration Records revealed R57 had an order dated 8/3/17, for Lantus 20 units daily. R57 had received Lantus 20 units from 10/1/17, through 10/24/17. R57 received Lantus from an expired vial for six days after it expired. R57's October Medication Administration Records revealed R57 had an order dated 9/18/17, for Novolog insulin three times a day based on blood sugars greater than 249 mg/dl. R57 had received six doses of Novolog insulin after 10/18/17.

During interview on 10/24/17, at 1:04 p.m. facility Medical Director giving a resident expired insulin would be a medication error.

During interview on 10/26/17, at 2:32 p.m. the director of nurses (DON) stated she would have expected the nurses to check the date open for any vial of insulin and if expired the nurses would not give the expired insulin. The DON stated Lantus and NovoLog are only good for 28 days from the time they were removed from the fridge or when they were opened. The DON stated giving expired insulin would be a medication error.

Food and Drug Administration Novolog drug

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| 21545 | Continued From page 24<br>insert NDA 20-986/S-032 dated 2006, indicated "NovoLog in unopened vials, cartridges, and NovoLog FlexPen Prefilled syringes should be stored between 2° and 8°C (36° to 46°F). Do not freeze. Do not use NovoLog if it has been frozen or exposed to temperatures that exceed 37°C (98.6°F). After a vial, cartridge, or Prefilled syringe has been punctured, it may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight."<br><br>Sanofi-aventis Lantus medication insert revised 8/2015, indicated Lantus could be stored for 28 days at room temperature if the vial was opened or unopened.<br><br>Medication Administration Subcutaneous Insulin policy dated 5/16, instructed staff, "5. Obtain insulin. Check expiration date. If refrigerated, allow warming to room temperature. ... 6. Date vial or device after first use."<br><br>SUGGESTED METHOD OF CORRECTION: The facility administrator and director of nursing (DON) or designee could review facility policies and procedures, educate staff and implement an ongoing monitoring system to ensure all resident orders are correctly transcribed and implemented as directed by physician orders.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21545 | | |
| 21565 | MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin<br><br>Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive | 21565 | | 12/6/17 |

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| 21565 | Continued From page 25<br>resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure self-administration of medications was allowed for 1 of 1 resident (R186) only after an assessment determined it was safe.<br><br>Findings include:<br><br>R186's room was observed on 10/24/17, at 10:16 a.m. and an Ventolin inhaler (medication used to open the airway) was observed on top of the resident's nightstand available for use.<br><br>R186 was interviewed on 10/24/17, at 10:45 a.m. R186 said she kept the inhaler on her nightstand and used it when she needed it.<br><br>The Admission Face Sheet on R186's record indicated she had been admitted 5/28/15, with a diagnosis that included chronic obstructive pulmonary disease.<br><br>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)."<br><br>Review of R186's self-administration of medication assessment dated 9/26/17, indicated R186 was to have the nursing staff administer the medication. | 21565 | 1. R186 has had a self administration of medications assessment completed with care plans updated as needed.<br>2. A self-administration of medications assessment has been completed on any other residents wishing to self-administer medications at the bedside.<br>3. Staff will be re-educated on the need for accurate completion of a self-administration of medication for any resident that wishes to self-administer medications.<br>4. Nursing leadership will assess medication administration competency for 5 nurses per week until all Nurses have been assessed.<br>5. Nursing leadership will audit the accuracy of the self administration of medications assessment with each quarterly, annual, or significant change of condition MDS.<br>6. The audits will be reviewed and any identified concerns will be brought to the facility QAPI committee for further recommendations.<br>7. The Director of Nursing remains responsible to ensure residents are assessed for the ability to self-administer medications. | |

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| 21565 | Continued From page 26<br><br>On 10/24/17, at 10:19 a.m. registered nurse-F verified R186 had an order to leave the medication at the bedside, but was not assessed to self-administer the medication.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nurses could inservice staff regarding the process for determination of resident capability to safely self-administer medications. An audit could be conducted to identify and assess residents who have the capability to participate in self-administration. This could be part of the quality assurance plan.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days. | 21565 | | |
| 21610 | MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage<br><br>Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 4 of 20 residents (R221, R15, R127, R57) who received Lantus (a long acting insulin used for the treatment of elevated blood sugars) did not receive expired medication and 1 of 8 residents (R57) who received NovoLog (a short acting insulin for the treatment of elevated blood sugars) did not receive expired medication.<br><br>Findings include: | 21610 | 1. The identified expired insulins were removed from the med carts as soon as notified about the concern during the annual survey.<br>2. 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. | 12/6/17 |

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| 21610 | Continued From page 27<br><br>R221's five-day Minimum Data Set (MDS) dated 9/14/17, indicated R221 was cognitively intact, received insulin injections seven days a week and had a diagnosis of diabetes mellitus (a disease where blood sugars are too high) with polyneuropathy (nerve damage related to diabetes).<br><br>During medication administration observation on 10/23/17, at 7:12 p.m. licensed practical nurse (LPN)-C prepared R221's Lantus 22 unit. The vial of Lantus was dated as opened 9/18/17. Prior to LPN-C entering R221's room surveyor stopped LPN-C and had him check the expiration date on the vial. LPN-C verified the Lantus was expired 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.<br><br>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 101mg/dl-207mg/dl during the period of time from 10/16 through 10/23/17.<br><br>R15's quarterly MDS dated 9/9/17, indicated R15 was moderately independent with decision making, received insulin injections seven days a week and had a diagnosis of diabetes mellitus.<br><br>During medication cart observation on 10/23/17, at 7:21 p.m. Lantus vial for R15 was observed | 21610 | 3. All other residents with an order for Insulin have had their insulin checked for expiration dates.<br>4. Licensed Nurses will be in-serviced on medication administration and storage<br>5. Licensed Nurses have been assigned education on medication administration and Diabetes through Health Care Academy to be completed by 12/6/17.<br>6. PharMerica Nurse Consultant will conduct a medication administration and storage audit on 11/28/17 and 11/29/17.<br>7. All Nurses will complete a medication storage self competency each shift they work until the next QAPI meeting 12/19/17.<br>8. Nursing leadership will complete Medication administration competency assessments on 5 Nurses per week until all Nurses have been assessed.<br>9. Nursing leadership will complete 5 medication storage competency audits weekly until the next QAPI meeting 12/19/17.<br>10. The facility QAPI committee will review completed audits and medication error reports monthly and make further recommendations.<br>11. See also F333.<br>12. The Director of Nursing remains responsible for compliance with this requirement to ensure that pharmaceutical services are provided to meet the needs of each resident. | |

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| 21610 | Continued From page 28 | 21610 | | |

with a date open of 9/22/17. LPN-D verified the vial had been dated as opened 9/22/17, and stated Lantus was only good for 28 days. R15 stated R15 had received Lantus that day. Twenty-eight days from 9/22/17, was 10/19/17.

R15's October 2017 Medication Administration Records revealed R15 had an order dated 9/26/17, for Lantus 12 units daily. R15 received Lantus 20 units from 10/1/17, through 10/23/17. R15 received Lantus from an expired vial for four days. R15's blood sugars varied from 124mg/dl-278 mg/dl during the period of time from 10/19/ through 10/23/17.

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.

During medication cart observation on 10/23/17, at 7:24 p.m. Lantus vial for R127 was observed with a sticker on it that indicated date open of 9/17/17, and expiration date of 10/15/17. Registered nurse (RN)-G stated R127 was currently in the hospital and had been admitted to the hospital on 10/28/17. RN-G verified date on Lantus vial indicated it had been opened 9/17/17, and stated Lantus was only good for 28 days.

R127's October 2017 Medication Administration Records revealed R127 had an order dated 10/9/17, for Lantus 20 units daily. R127 had received Lantus 20 units from 10/11-10/19/17. R127 received Lantus from an expired vial for four days after it expired.

R127 Occurrence report closed 10/25/17, indicated R127's Lantus vial was opened 9/17/17,

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| 21610 | Continued From page 29<br>and should have been discarded 10/15/17.<br><br>R57's quarterly MDS dated 9/20/17, indicated R57 was severely cognitively impaired received insulin injections seven days a week and had a diagnosis of diabetes mellitus.<br><br>During medication cart observation on 10/24/17, at 9:46 a.m. Lantus vial for R57 was observed with a sticker on it that indicated date open of 9/21/17, LPN-E verified R57 received Lantus that morning. LPN-E stated she had given the Lantus and for some reason had not checked the date the Lantus vial was opened. LPN-E stated the vial should have been disposed of on 10/18/17. LPN-E verified R57 had a vial of NovoLog in the medication cart dated opened 9/21/17 which should have been disposed of at the end of the day on 10/18/17. LPN-E stated R57 had not received NovoLog that day. LPN-E stated an expired medication that was given would be a medication error.<br><br>During interview on 10/24/17, at 10:01 a.m. RN-D stated giving expired insulin would be a medication error.<br><br>R57's October 2017 Medication Administration Records revealed R57 had an order dated 8/3/17, for Lantus 20 units daily. R57 had received Lantus 20 units from 10/1/17, through 10/24/17. R57 received Lantus from an expired vial for six days after it expired. R57's October Medication Administration Records revealed R57 had an order dated 9/18/17, for Novolog insulin three times a day based on blood sugars greater than 249 mg/dl. R57 had received six doses of Novolog insulin after 10/18/17. | 21610 | | |

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| 21610 | Continued From page 30 | 21610 | | |

During interview on 10/24/17, at 1:04 p.m. facility Medical Director giving a resident expired insulin would be a medication error.

During interview on 10/26/17, at 2:32 p.m. the director of nurses (DON) stated she would have expected the nurses to check the date open for any vial of insulin and if expired the nurses would not give the expired insulin. The DON stated Lantus and NovoLog are only good for 28 days from the time they were removed from the fridge or when they were opened. The DON stated giving expired insulin would be a medication error.

Food and Drug Administration Novolog drug insert NDA 20-986/S-032 dated 2006, indicated "NovoLog in unopened vials, cartridges, and NovoLog FlexPen Prefilled syringes should be stored between 2° and 8℃ (36° to 46℉). Do not freeze. Do not use NovoLog if it has been frozen or exposed to temperatures that exceed 37℃ (98.6℉). After a vial, cartridge, or Prefilled syringe has been punctured, it may be kept at temperatures below 30℃ (86℉) for up to 28 days, but should not be exposed to excessive heat or sunlight."

Sanofi-aventis Lantus medication insert revised 8/2015, indicated Lantus could be stored for 28 days at room temperature if the vial was opened or unopened.

Facility policy Storage of Medication dated 5/16, instructed staff, "12. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in refrigerator or at room temperature... 14. Outdated, contaminated, discontinued or

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| 21610 | Continued From page 31<br>deteriorated medications and those that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal..."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure medications including vaccination solution, are appropriately stored and not expired. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) Days | 21610 | | |
| 21665 | MN Rule 4658.1400 Physical Environment<br><br>A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure a sanitary environment for 10 of 11 residents (R271, R110, R40, R26, R14, R45, R267, R191, R34, R45).<br><br>Findings include:<br><br>R271 was admitted 12/3/16, and discharged back | 21665 | 1. 10 out of 10 resident environmental concerns were immediately addressed.<br>2. Each resident room and resident bathroom in the facility was reviewed for cleanliness.<br>3. Each resident wheelchair was reviewed for cleanliness and repair.<br>4. Each resident grab bar was reviewed | 12/6/17 |

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| 21665 | Continued From page 32<br>to hospital by 911 on 4/3/17 per the Face Sheet. The admission diagnoses include Parkinson's disease, dementia, dysphagia (inability to swallow food safely) with feeding tube for nutrition, unable to communicate, history of heart bypass and kidney cancer with urine retention and suprapubic Foley catheter. R271 required extensive assistance with bed mobility, transfers, and toilet use; was totally dependent on staff for dressing and eating (tube feeding). On 4/3/17, R271's spouse complained of feces and urine on toilet seat, and unclean room.<br><br>R110 had an annual Minimum Data Set (MDS) assessment on 8/11/17, had moderate cognitive impairment, and did not reject cares, and needed extensive assistance of two staff for bed mobility, transfers and toilet use. On 10/24/17, at 9:07 a.m. R110's call light was very hard to press to activate the light. R110's room had paint off the entire length of the wall heat register. R110's wheelchair armrests were missing the vinyl covering which made the wheelchair uncleanable.<br><br>R40 quarterly MDS review dated 7/25/17, indicated R40 was cognitively intact, had moderately severe depression, and was independent with supervision for cares. On 10/24/17, at 9:10 a.m. R40's wheelchair armrests were tattered, with vinyl missing making it an uncleanable surface. In addition, the wheelchair cushion remained uncleaned. R40's call light was detached from the wall. When he needed help he would stand up, reach over the rolling tray table with multiple beverages and items on it, blocking the way to the call light on the wall. At 10:00 a.m. on 10/24/17, registered nurse (RN)-H stated aides should be checking for working call lights.<br><br>R40's room was observed on 10/24/17, at 10:53 | 21665 | to ensure material is intact.<br>5. Each resident call light has been audited for function and placement.<br>6. Each resident room has been checked for extra cable boxes.<br>7. Housekeeping policies were reviewed and all Housekeeping staff were re-educated on proper cleaning techniques.<br>8. The housekeeping and maintenance department will conduct environmental audits of items #2-#5 weekly until the next facility QAPI meeting on 12/19/2017.<br>9. The facility QAPI committee will review completed audit results and make further recommendations.<br>10. The Executive Director remains responsible for compliance with this requirement, to ensure that residents are provided a safe, functional, sanitary, and comfortable environment. | |

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| **ST ANTHONY HEALTH & REHABILITATION** | **3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421** |

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| 21665 | Continued From page 33<br>a.m. R40's the surfaces of both the manual wheelchair arm rests were cracked and areas of white padding were clearly visible. More areas of padding were exposed on front of both armrests and appeared to be soiled with a light brown substance.<br><br>During a tour on 10/26/17, at 1:39 p.m. the acting maintenance director and the housekeeping director said surface of the armrests could not be cleaned.<br><br>R26's annual assessment dated 9/22/17, indicated R27 had severely impaired cognition, and needed extensive assistance of two staff for bed mobility, transfers and toilet use. On10/23/17, at 4:19 p.m. R26's call light was trapped under mattress. R26 was unable to reach it. R26 stated she can use it to get staff. On 10/23/17, at 4:19 p.m. licensed practical nurse (LPN)-C came into room as requested and put the call light close to R26.<br><br>R14 was admitted 9/25/17, per the Face Sheet. On 10/24/17, at 9:50 a.m. R14 stated the sink was not kept clean in the bathroom. Staff clean the sink, but it gets dirty fast and "I cannot use the sink when it's dirty because of my colostomy." There was missing grout around the base of heater.<br><br>R45's quarterly MDS review dated 8/25/17, indicated R45 was cognitively intact, needed extensive assistance of two staff for bed mobility, transfers and toilet use. On 10/23/17, at 7:47 p.m. the grab bars on the bed had foam peeling off and were no longer a cleanable surface.<br><br>R267 was admitted to the facility on 10/11/17, per the Face Sheet. On 10/24/2017, at 11:07 a.m. | 21665 | | |

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| 21665 | Continued From page 34 | 21665 | | |

R267 stated sometimes the bathroom was not clean, "like today I walked in there and it wasn't clean, I told staff and housekeeping came had to come in and clean it."

R191's re-admission MDS assessment dated 9/12/17, indicated R191 was cognitively intact with minimal depression, and needed extensive assistance of two staff for bed mobility, transfers and toilet use. On 10/24/17, at 1:08 p.m. there was a medium sized brown stain on grout of toilet base.

R34's quarterly review MDS dated 9/29/17, indicated R34 was cognitively intact with minimal depression, and needed limited assistance of one staff for bed mobility, transfers and toilet use.

R34's room was observed on 10/23/17, at approximately 7:00 p.m. R34's room was observed to contain a cable internet box hanging by two cables approximately six inches out of the wall, about two feet to the right of the head of R34's bed, between the headboard and the window.

R34 was interviewed at the time of the observation and said some man had left it there and it had been there for months. R34 said the man had given her a television remote. R34 picked up the remote from her bedside stand, still wrapped in plastic.

A printed email communications dated 5/12/17, from the maintenance director to the facility administrator indicated cable instillation was to take place on May 12, 2017.

R45's room was observed on 10/23/17, at

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| 21665 | Continued From page 35<br>approximately 7:00 p.m., R45's bed right side grab bar was observed to have foam on the top of the bar that was ripped, with approximately three inches missing.<br><br>During a tour on 10/26/17, at 1:39 p.m. the acting maintenance director and the housekeeping director said surface of the grab bar could not be cleaned.<br><br>2 North Unit:<br>On 10/23/17, at approximately 7:00 p.m., the ceiling vents near the fire door on 2 North unit were noted to have a fine gray substance on the surfaces of all of the grates in each vent. The same substance was noted on the ceiling tiles touching the ceiling vents.<br><br>During an interview on 10/25/17, at 2:18 p.m., the housekeeping director said the housekeeping staff should have cleaned the ceiling vents. The housekeeping director said a member of the housekeeping staff should have notified the maintenance department about the wheelchair arms, the damaged side rail and the cable box hanging from the wall. The housekeeping director said the housekeeping staff inspected resident areas as part of their daily cleaning schedule and were instructed to call the maintenance department if a concern was identified and leave a voicemail message on the Maintenance Connection line to initiate maintenance work order.<br><br>During an interview on 10/25/17, at 10:53 a.m., the acting director of maintenance said she checked the Maintenance Connect line daily and compiled a list of work orders. She said the work orders were stored in this list until completed. A list or work orders was provided, with work orders | 21665 | | |

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| 21665 | Continued From page 36<br>dating back three months.<br><br>During an interview with the administrator on 10/26/17, at 9:31 a.m., she said she expected the maintenance department to prioritize the work orders. After reviewing the current list of work orders, the facility administrator said she was surprised by the number of unfinished work orders and said she questioned about how the work orders been prioritized.<br><br>The Maintenance Work Order/Repair Requisition policy and Procedure last reviewed on 8/09 instructed any employee to call and report environmental risks and to request service.<br><br>SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff and conduct periodic audits of areas residents frequent to ensure a home like environment is obtained to the extent possible.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 21665 | | |
| 21800 | MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a | 21800 | | 12/6/17 |

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| 21800 | Continued From page 37<br>person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide the appropriate notices for discontinuation of services for 2 of 4 residents (R7, R8) who remained in the facility following a Medicare covered stay.<br><br>Findings include:<br><br>R8 received a Notice of Medicare Non-Coverage dated 1/24/17, for a coverage end date of 1/26/17. R8 remained in the facility, with 79 Medicare days remaining but did not receive a determination of continued stay.<br><br>R8 received a Notice of Medicare Non-Coverage but refused to sign, for a coverage end date of 7/24/17. R8 remained in the facility, with 80 | 21800 | 1. R7 remains in the facility. R8 has been discharged,<br>2. The appropriate Notice of Medicare Non-Coverage forms have been initiated.<br>3. The facility has developed a Medicare Notice procedure.<br>4. The facility MDS coordinators and Social Workers have been in-serviced on the Medicare Notice procedure.<br>5. Facility leadership will audit 1 end of coverage notice per week for appropriate notice until the next facility QAPI meeting on 12/19/17.<br>6. The facility QA&A committee will review completed audit results and make further recommendations.<br>7. The Executive Director remains | |

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| 21800 | Continued From page 38<br>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.<br><br>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.<br><br>R7 received a Notice of Medicare Non-Coverage dated 10/27/17, for a coverage end date of 10/27/17. R7 remained in the facility, with 52 Medicare days remaining but did not receive a determination of continued stay.<br><br>During an interview on 10/27/17, at 7:45 a.m., LSW-A stated the Minimum Data Set (MDS) Coordinator provided education on the Notice of Medicare Non-Coverage. LSW-A further indicated that the MDS Coordinator gave the social workers a form to issue to residents and/or families and make sure they know they have a right to appeal. LSW-A verified they only gave one form (Form CMS 10123) and they also gave a denial letter from Humana if applicable to the resident.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures and could develop monitoring systems to ensure | 21800 | responsible for compliance with this requirement, to ensure each resident receives notice of changes in coverage | |

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| 21800 | Continued From page 39<br>ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) Days. | 21800 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide care in a dignified manner for 1 of 5 residents (R150) who required assistance with activities of daily living.<br><br>Findings include:<br><br>During observation on 10/25/17, at 1:38 p.m. nursing assistant (NA)-B stood R150 utilizing the mechanical lift in the bathroom. There were two large wet spots on the back of the resident's pants. NA-B said, "Between her and [another resident's name], I don't know who wets the most." Registered nurse (RN)-C who was also present added, "They wet a lot." NA-B remarked, "I would swear these two drank 50 gallons a day and take water pills." NA-B and RN-C made these statements in front of R150.<br><br>R150's quarterly Minimum Data Set (MDS) dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the | 21805 | 1. The identified resident R150 has had her care plans and NAR assignment sheets reviewed and updated as needed to include providing for privacy and dignity.<br>2. The responsible staff were re-educated on privacy and dignity as soon as notified of the concern during the annual survey.<br>3. Staff will be re-trained on providing for resident privacy and dignity using specific examples cited in the CMS-2567.<br>4. Nursing leadership will assess privacy and dignity competency on 6 staff members a week until all nursing staff have been assessed.<br>5. Nursing leadership will also look at potential privacy and dignity issues while completing various scheduled audits such as med pass audits, NAR direct care audits, toileting, etc.<br>6. The Director of Nursing will review the completed audits and bring any identified privacy concerns to the facility QAPI | 12/6/17 |

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| 21805 | Continued From page 40<br>cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all ADLs and R150 was frequently incontinent of bladder and bowel.<br><br>During interview on 10/25/17, at 2:07 p.m. NA-B verified making the statements in front of R150 and stated she was nervous.<br><br>During interview on 10/25/17, at 2:22 p.m. RN-C stated she thought NA-B was trying to provide information to explain that all residents were changed every two hours. RN-C confirmed NA-B should have waited to explain that until they were done providing R150's care.<br><br>SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on dignity and respect. The DON or designee could then interview residents routinely to ensure residents feel their dignity and respect are being maintained.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 21805 | committee for review and further recommendations.<br>7. The Director of Nursing remains responsible for compliance with this requirement to ensure residents the right to personal privacy and confidentiality.<br>8. See also F164 | |
| 21810 | MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. | 21810 | | 12/6/17 |

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| 21810 | Continued From page 41<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure a call light was easily accessible in order to summon staff assistance for 1of 6 residents (R26) observed to have a call light not in within reach.<br><br>Findings include:<br><br>R26's care plan effective 1/26/15, to present, indicated R26 had impaired vision and instructed staff to keep the call light with-in reach.<br><br>R26's annual Minimum Data Set (MDS) dated 9/22/17, indicated R26 had moderate cognitive impairment and required extensive assistance from two staff members for activities of daily living (ADLs) that involved mobility. The MDS also identified R26 for being at risk for falls.<br><br>On 10/23/17, at 4:19 p.m. R26 was observed in their room, seated in a manual wheelchair, near the end of the bed facing the wall. R26's call light button placed under the mattress and R26 was unable to reach the call light. R26 indicated she did use the call light to get staff. At 4:19 p.m. licensed practical nurse (LPN)-B verified the call light was not within R26's reach and proceeded to reposition the call light for R26's so it was within the reach.<br><br>During an interview on 10/26/17, at 9:00 a.m. the director of nursing said call lights should be checked every time there was staff in the room; whoever walked in that room should be checking.<br><br>The facility policy titled accessible call lights dated 11/20/15, directed the facility to determine the | 21810 | 1. Resident R28 care plans and NAR assignment sheets have been reviewed and updated as needed.<br>2. Staff will be re-trained on providing for resident accommodation of needs, using specific survey examples cited in the 2567.<br>3. Facility leadership will complete call light placement audits 2x/week until the next QAPI meeting 12/19/17.<br>4. The Director of Nursing will review the completed audits and bring any identified concerns to the facility QAPI committee for review and further recommendations.<br>5. The Executive Director remains responsible for compliance with this requirement to ensure residents are provided services with reasonable accommodation of individual needs. | |

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| 21810 | Continued From page 42<br>resident had a call light with reach. The protocol stated "Call lights must always be placed in the reach of the resident."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure call lights are kept within resident reach. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21810 | | |
| 21855 | MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to maintain privacy of a resident's personal care related information for 1 of 5 residents (R83) reviewed who was dependent upon staff for activities of daily living | 21855 | 1. The identified resident R83 has had her care plans and NAR assignment sheets reviewed and updated as needed to include providing for privacy and dignity.<br>2. The responsible staff were | 12/6/17 |

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| 21855 | Continued From page 43<br>(ADLs).<br><br>Findings include:<br><br>During observation on 10/25/17, at 1:38 p.m. nursing assistant (NA)-B stood R150 utilizing the mechanical lift in the bathroom. There were two large wet spots on the back of the resident's pants. NA-B said, "Between her and [R83], I don't know who wets the most." Registered nurse (RN)-C who was also present added, "They wet a lot." NA-B remarked, "I would swear these two drank 50 gallons a day and take water pills." NA-B and RN-C made these statements in front of R150 about R83's incontinence.<br><br>R150's quarterly Minimum Data Set (MDS) dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all ADLs and R150 was frequently incontinent of bladder and bowel.<br><br>R83's quarterly MDS dated 9/20/17, indicated R83 had dementia and was unable to complete the cognitive portion of the MDS. The MDS further indicated R83 required extensive assist with all ADLs and R83 was frequently incontinent of bladder and bowel.<br><br>During interview on 10/25/17, at 2:07 p.m. NA-B verified making the statement about R83's incontinence in front of R150 and stated she was nervous.<br><br>During interview on 10/25/17, at 2:22 p.m. RN-C stated she thought NA-B was trying to provide information to explain that all residents were changed every two hours and R83 was changed | 21855 | re-educated on privacy and dignity as soon as notified of the concern during the annual survey.<br>3. Staff will be re-trained on providing for resident privacy and dignity using specific examples cited in the CMS-2567.<br>4. Nursing leadership will assess privacy and dignity competency on 6 staff members a week until all nursing staff have been assessed.<br>5. Nursing leadership will also look at potential privacy and dignity issues while completing various scheduled audits such as med pass audits, NAR direct care audits, toileting, etc.<br>6. The Director of Nursing will review the completed audits and bring any identified privacy concerns to the facility QAPI committee for review and further recommendations.<br>7. The Director of Nursing remains responsible for compliance with this requirement to ensure residents the right to personal privacy and confidentiality.<br>8. See also F241 | |

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| 21855 | Continued From page 44<br>more often. RN-C confirmed NA-B should have waited to explain that until they were done providing R150's care.<br><br>During interview on 10/25/17, at 2:49 p.m. RN-D stated staff "should be focused on the resident they are working with and not talk about any other resident."<br><br>During interview on 10/26/17, at 2:32 p.m. the director of nursing verified the staff should not have discussed R83 while providing care to R150.<br><br>The facility's Confidentiality policy dated 6/26/12, included: "Staff will not discuss any client information in locations where these conversations may be overheard by unauthorized persons, such as other clients or visitors."<br><br>Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director to update policies and procedures related to resident's right to privacy and then educate staff of these rights. The DON or designee could also perform audits of resident records to determine this right had been protected.<br><br>Time Period for Correction: Twenty-one (21) days. | 21855 | | |
| 21995 | MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults<br><br>Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases | 21995 | | 12/6/17 |

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| 21995 | Continued From page 45<br>of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to operationalize their abuse prevention policy for 1 of 1 resident (R31), who alleged verbal abuse with derogatory comments made by staff. In addition, the facility failed to ensure a bruise of unknown origin located on a resident's thigh was reported to the State agency (SA) in a timely manner for 1 of 1 resident (R150).<br><br>Findings include:<br><br>R31 was admitted to the facility on 3/24/17. The Face Sheet in the resident's record indicated diagnoses including: spinal stenosis of neck, compression fracture of first lumbar vertebra, muscle weakness, diabetes, and history of stroke.<br><br>During an interview with R31 on 10/24/17, at 1:18 p.m. R31 stated she had "complained to a nurse that nursing assistant (NA)-[G] emotionally hurt her when she called her the devil about 20 times." R31 stated "[NA-G] said nobody out here likes you because you're the devil." R31 stated she had reported the incident to the nurse who was working that night.<br><br>R31's care plan dated 7/26/17, directed staff to explain cares and procedures prior to performing, | 21995 | 1. The allegation of abuse by R31 has been reported and investigated. The bruise for R150 has been investigated.<br>2. The facility Vulnerable Adult Abuse Prevention policy and procedure has been reviewed and remains appropriate.<br>3. The Administrator and DON attended VAA education at Care Providers joint training on 11/7/17.<br>4. Staff have been re-educated on the facility Vulnerable Adult Abuse Prevention policy and program.<br>5. The IDT will review each incident to determine if reportable and appropriate preventative measures are put in place.<br>6. The facility QAPI committee will review all incidents monthly.<br>7. See also F225.<br>8. The Executive Director remains responsible for compliance with this requirement, to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately | |

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offer validation of feelings, social service note in chart "prefers male care givers", abuse prevention, monitor for all signs and symptoms, accusations of abuse or neglect. Investigate and report all signs and symptoms of abuse or neglect. Staff to assist resident out of dining room to prevent bumping into or altercations with other 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, incontinence cares, and also experienced some pain. The assessment further indicated R31 had no behavioral issues and was not receiving any psychoactive medications.

Registered nurse (RN)-H was interviewed on 10/25/17, at 2:23 p.m. and stated she had received a voicemail from the nurse who had been working on the evening of 10/22/17, regarding R31's complaint of being called the devil. RN-H said she had followed up with R31 the next day. RN-H stated NA-G had denied the incident had ever happened, but was instructed not to take care of R31 again. RN-H said R31 had been satisfied with not having NA-G take care of her, so the concern had been documented on a grievance form. RN-H said R31 "did not call it emotional abuse" so it was not reported to the administrator, director of nursing (DON), or the SA. RN-H further stated that she had received another complaint about NA-G from a daughter of another family, whose roommate

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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.

On 10/25/17, a note was documented in R31's medical record by the director of nursing (DON) that indicated: on 10/22/17, R31 complained to nurse that she did not want the new NA assigned to her to care for her any longer. R31 stated to nurse "I don't like her, she called me evil." The nurse asked NA if she called resident evil and NA stated "No." The nurse re-assigned NA and resident was satisfied. The documentation on 10/25/17, further indicated on 10/23/17, the nurse manager followed up with resident on her concern, notified resident that NA would be assigned to another floor and resident was satisfied. The resident did not make any statements of feeling verbal abuse occurred. Documentation continued on 10/25/17, noted the resident stated to MDH (Minnesota Department of Health) surveyor that she had been verbally abused by a NA who called her evil. The administrator was notified, investigation initiated and was on-going NA has already been assigned to another nursing unit with extra orientation and supervision, so NA will no longer care for the resident.

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's

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new and I just don't like her.' R31 doesn't like new people at all." The DON further stated her expectation of staff was if an allegation of abuse was made, staff would inform the administrator and DON immediately. She added that since a complaint/ grievance form had been used, she'd thought R31 just did not like that particular nursing assistant. In addition, the DON said she didn't think it was an emotionally distraught situation. The DON also stated RN-I had spoken to the resident right away and asked if she would feel comfortable if they moved that staff to another part of the building which R31 had indicated would be ok. However, the DON verified that calling resident's names was verbal abuse, and a resident did not have to say they were verbally abused for it to be reported as abuse.

The facility failed to report an allegation of verbal/emotional abuse in a timely manner to the administrator, DON, and State agency and fully investigate the allegation.

R150's quarterly MDS dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all activities of daily living (ADLs) including transfers and ambulation.

An Occurrence Report closed 10/6/17, revealed that on 10/3/17, at 7:30 a.m. during morning cares R150 had a bruise on her right inner thigh which measured 10 centimeter (cm) by 9 cm. Per the occurrence report, R150 was unable to explain how she sustained it. Licensed practical nurse documented, "Res [Resident] must have bumped herself into the Broda chair arm rest during transfer. Maltreatment and abuse is not indicated." Occurrence Report wound description

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indicated wound was blackened. Report indicated R150 sometimes required assist of two with transfers due to behaviors. The occurrence report indicated in the Conclusion section of report dated 10/5/17, at 11:54 a.m. the IDT reviewed bruise incident. The conclusion section of report indicated R150 had a history of being resistive to cares, striking out at staff during cares, would attempt to self-transfer, R150 required staff assistance to transfer. Occurrence Report indicated resident bruise was in a non-hand grasp pattern and bruise lined up with the armrest of the Broda chair, and bruise was likely to have happened when R150 was attempting to sit down into the chair. Intervention implemented was "Staff will cont [continue] to use caution when assisting this resident and use Montessori techniques to have res cooperative with cares." The Occurrence Report did not indicate notification of facility administrator or director of nursing.

Review of progress notes from 9/3/17, through 10/24/17, did not reveal notification of the administrator of the bruise. Review of progress notes did not indicate any instance of R150 sitting on arm of Broda chair.

The Hospice and Palliative Care Facility Visit Documentation Record dated 10/16/17, revealed R150 was very anxious grabbing and upset with cares. R150 was more difficult to redirect with cares and had a fading bruise on right inner thigh.

R150's care plan printed 10/26/17, indicated R150 required assist of one staff member for transfers from 8/8/17 until 10/24/17, when care plan was updated. The intervention dated 8/23/17, instructed staff to monitor R150 closely and intervene when resident attempted to

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self-transfer and that staff would intervene when able to assist resident to sit on correct seating as able.

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.

During interview on 10/26/17, at 12:01 p.m. the 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 nurse manager did the IDT on 10/5/17. 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

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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 administrator was unable to say when she was 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

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| 21995 | Continued From page 52<br>treatment or exploitation of a resident.<br>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 disability.<br>7. Physical Abuse includes, but not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.<br>9. Neglect is the failure of the facility, it's 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.<br><br>SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee(s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee(s) could monitor to assure all reports of abuse are being reported and investigated.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21995 | | |
| 22000 | MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults | 22000 | | 12/6/17 |

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Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal

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| 22000 | Continued From page 54<br>misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>The facility Abuse, Neglect and Exploitation policy approved 11/28/16, indicated mandated reporters will immediately report to the:<br>" Administrator/Executive Director<br>" Other Officials in accordance with State Law<br>" State Survey and Certification agency following state protocols.<br>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, | 22000 | 1. The allegation of abuse by R31 has been reported and investigated. The bruise for R150 has been investigated.<br>2. The facility Vulnerable Adult Abuse Prevention policy and procedure has been reviewed and remains appropriate.<br>3. The Administrator and DON attended VAA education at Care Providers joint training on 11/7/17.<br>4. Staff have been re-educated on the facility Vulnerable Adult Abuse Prevention policy and program.<br>5. The IDT will review each incident to determine if reportable and appropriate preventative measures are put in place.<br>6. The facility QAPI committee will review all incidents monthly.<br>7. See also F226.<br>8. The Executive Director remains responsible for compliance with this requirement, to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately. | |

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|---|---|---|---|
| | 00522 | A. BUILDING: ______ B. WING ______ | C 10/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **ST ANTHONY HEALTH & REHABILITATION** | **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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 22000 | Continued From page 55 | 22000 | | |

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 disability.

7. Physical Abuse includes, but not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

9. Neglect is the failure of the facility, it's 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.

During an interview with R31 on 10/24/17, at 1:18 p.m. R31 stated she had "complained to a nurse that nursing assistant (NA)-[G] emotionally hurt her when she called her the devil about 20 times." R31 stated "[NA-G] said nobody out here likes you because you're the devil." R31 stated she had reported the incident to the nurse who was working that night.

R31 was admitted to the facility on 3/24/17. The

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| | 00522 | A. BUILDING: ________ B. WING ________ | C 10/27/2017 |

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| **ST ANTHONY HEALTH & REHABILITATION** | **3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421** |

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| 22000 | Continued From page 56<br><br>Face Sheet in the resident's record indicated diagnoses including: spinal stenosis of neck, compression fracture of first lumbar vertebra, muscle weakness, diabetes, and history of stroke.<br><br>R31's care plan dated 7/26/17, directed staff to explain cares and procedures prior to performing, offer validation of feelings, social service note in chart "prefers male care givers", abuse prevention, monitor for all signs and symptoms, accusations of abuse or neglect. Investigate and report all signs and symptoms of abuse or neglect. Staff to assist resident out of dining room to prevent bumping into or altercations with other 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.<br><br>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, incontinence cares, and also experienced some pain. The assessment further indicated R31 had no behavioral issues and was not receiving any psychoactive medications.<br><br>Registered nurse (RN)-H was interviewed on 10/25/17, at 2:23 p.m. and stated she had received a voicemail from the nurse who had been working on the evening of 10/22/17, regarding R31's complaint of being called the devil. RN-H said she had followed up with R31 the next day. RN-H stated NA-G had denied the incident had ever happened, but was instructed not to take care of R31 again. RN-H said R31 | 22000 | | |

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| 22000 | Continued From page 57<br>had been satisfied with not having NA-G take care of her, so the concern had been documented on a grievance form. RN-H said R31 "did not call it emotional abuse" so it was not reported to the administrator, director of nursing (DON), or the SA. RN-H further stated that she had received another complaint about NA-G from a daughter of another family, whose roommate 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.<br><br>On 10/25/17, a note was documented in R31's medical record by the director of nursing (DON) that indicated: on 10/22/17, R31 complained to nurse that she did not want the new NA assigned to her to care for her any longer. R31 stated to nurse "I don't like her, she called me evil." The nurse asked NA if she called resident evil and NA stated "No." The nurse re-assigned NA and resident was satisfied. The documentation on 10/25/17, further indicated on 10/23/17, the nurse manager followed up with resident on her concern, notified resident that NA would be assigned to another floor and resident was satisfied. The resident did not make any statements of feeling verbal abuse occurred. Documentation continued on 10/25/17, noted the resident stated to MDH (Minnesota Department of Health) surveyor that she had been verbally abused by a NA who called her evil. The administrator was notified, investigation initiated and was on-going NA has already been assigned | 22000 | | |

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| ST ANTHONY HEALTH & REHABILITATION | 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421 |

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| 22000 | Continued From page 58 | 22000 | | |

to another nursing unit with extra orientation and supervision, so NA will no longer care for the resident.

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's new and I just don't like her.' R31 doesn't like new people at all." The DON further stated her expectation of staff was if an allegation of abuse was made, staff would inform the administrator and DON immediately. She added that since a complaint/ grievance form had been used, she'd thought R31 just did not like that particular nursing assistant. In addition, the DON said she didn't think it was an emotionally distraught situation. The DON also stated RN-I had spoken to the resident right away and asked if she would feel comfortable if they moved that staff to another part of the building which R31 had indicated would be ok. However, the DON verified that calling resident's names was verbal abuse, and a resident did not have to say they were verbally abused for it to be reported as abuse.

R150's quarterly MDS dated, 8/2/17, indicated R150 had dementia and Alzheimer's disease, and could not complete the cognitive portion of the MDS. The MDS further noted R150 was an extensive assist with all activities of daily living (ADLs) including transfers and ambulation.

An Occurrence Report closed 10/6/17, revealed that on 10/3/17, at 7:30 a.m. during morning cares R150 had a bruise on her right inner thigh which measured 10 centimeter (cm) by 9 cm. Per the occurrence report, R150 was unable to explain how she sustained it. Licensed practical nurse documented, "Res [Resident] must have

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| 22000 | Continued From page 59 | 22000 | | |

bumped herself into the Broda chair arm rest during transfer. Maltreatment and abuse is not indicated." Occurrence Report wound description indicated wound was blackened. Report indicated R150 sometimes required assist of two with transfers due to behaviors. The occurrence report indicated in the Conclusion section of report dated 10/5/17, at 11:54 a.m. the IDT reviewed bruise incident. The conclusion section of report indicated R150 had a history of being resistive to cares, striking out at staff during cares, would attempt to self-transfer, R150 required staff assistance to transfer. Occurrence Report indicated resident bruise was in a non-hand grasp pattern and bruise lined up with the armrest of the Broda chair, and bruise was likely to have happened when R150 was attempting to sit down into the chair. Intervention implemented was "Staff will cont [continue] to use caution when assisting this resident and use Montessori techniques to have res cooperative with cares." The Occurrence Report did not indicate notification of facility administrator or director of nursing.

Review of progress notes from 9/3/17, through 10/24/17, did not reveal notification of the administrator of the bruise. Review of progress notes did not indicate any instance of R150 sitting on arm of Broda chair.

The Hospice and Palliative Care Facility Visit Documentation Record dated 10/16/17, revealed R150 was very anxious grabbing and upset with cares. R150 was more difficult to redirect with cares and had a fading bruise on right inner thigh.

R150's care plan printed 10/26/17, indicated R150 required assist of one staff member for transfers from 8/8/17 until 10/24/17, when care

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| 22000 | Continued From page 60<br>plan was updated. The intervention dated 8/23/17, instructed staff to monitor R150 closely and intervene when resident attempted to self-transfer and that staff would intervene when able to assist resident to sit on correct seating as able.<br><br>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.<br><br>During interview on 10/26/17, at 12:01 p.m. the 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 nurse manager did the IDT on 10/5/17. 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 | 22000 | | |

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| 22000 | Continued From page 61<br>when she was informed of the bruise.<br><br>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."<br><br>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 administrator was unable to say when she was informed of R150's bruise.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could assess all residents in the facility for vulnerability of abuse risk factors and develop individual abuse prevention plans to minimize each residents risks for abuse. The administrator or designee could monitor for compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 22000 | | |

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

F5267026

PRINTED: 11/27/2017
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245267 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **10/27/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **ST ANTHONY HEALTH & REHABILITATION** | **3700 FOSS ROAD NORTHEAST**<br>**ST ANTHONY, MN 55421** |

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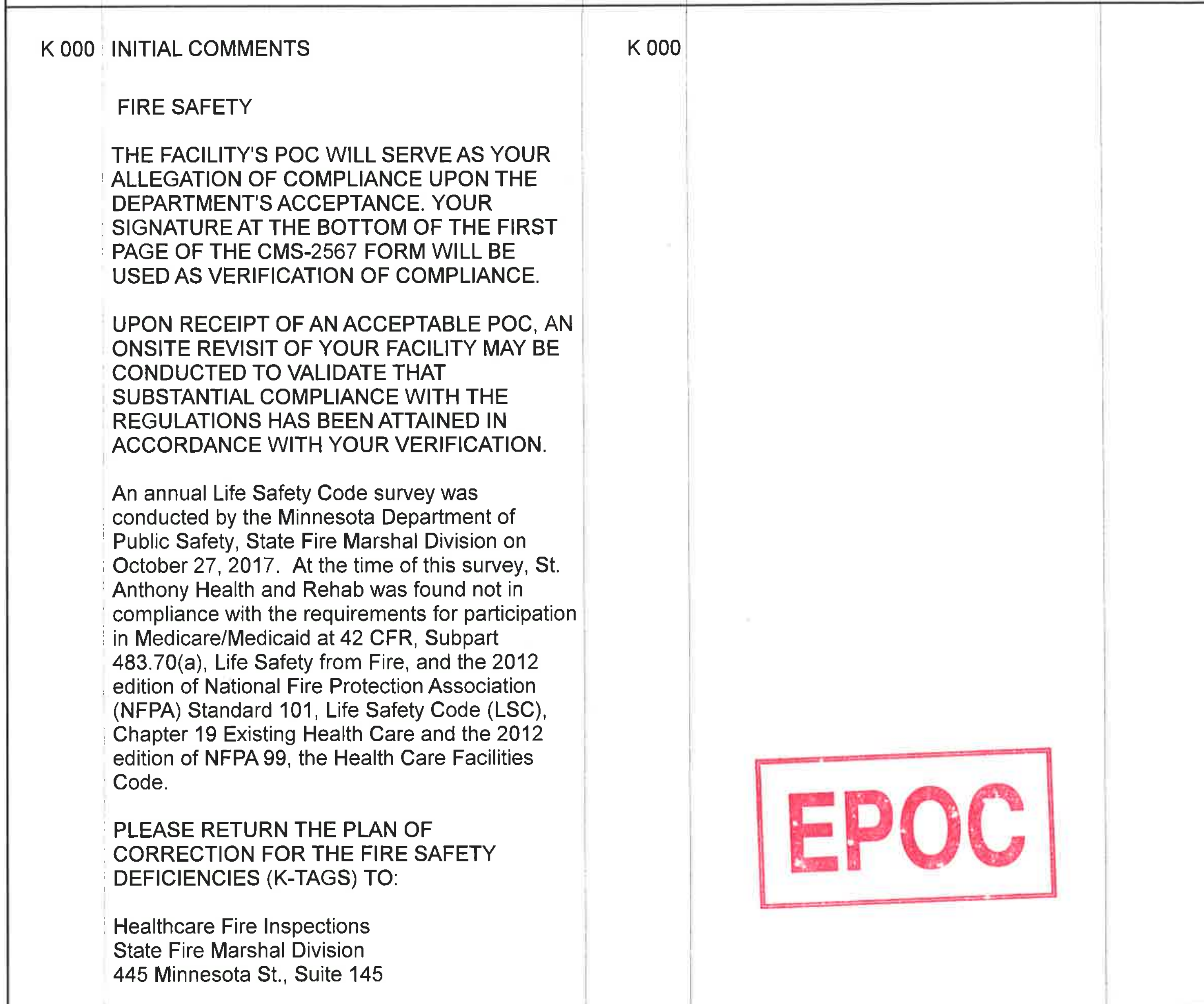

K 000 INITIAL COMMENTS — K 000

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-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



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 11/22/2017 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245267 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 10/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST ANTHONY HEALTH & REHABILITATION | 3700 FOSS ROAD NORTHEAST<br>ST ANTHONY, MN 55421 |

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| K 000 | Continued From page 1<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>St. Anthony Health Center is a 2-story building without basement that was built in 1967 and was determined to be of Type II(111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility shares a common wall with an assisted living facility that has a 2-hour fire rating.<br><br>The facility has a capacity of 140 beds and had a census of 127 at time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 353 SS=C | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101 | K 353 | | 11/15/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245267 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **10/27/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **ST ANTHONY HEALTH & REHABILITATION** | **3700 FOSS ROAD NORTHEAST**<br>**ST ANTHONY, MN 55421** |

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| K 353 | Continued From page 2<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>______<br>b) Who provided system test<br>______<br>c) Water system supply source<br>______<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and document review, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 127 residents.<br><br>Findings include:<br><br>On a facility tour between the hours of 1000 and 1500 on October 27, 2017, document review revealed that the facility could not provide evidence of having conducted a quarterly sprinkler flow test for the first quarter of 2017.<br><br>This deficient practice was verified by the | K 353 | 1. Upcoming sprinkler flow tests were immediately looked at for timeliness.<br>2. The next four quarters of sprinkler flow testing have been planned.<br>3. The Maintenance Director remains responsible for this requirement, to ensure our automatic fire sprinkler flow test is conducted quarterly. | |

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|---|---|---|---|
| | 245267 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 10/27/2017 |

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|---|---|---|---|---|
| K 353 | Continued From page 3<br>Maintenance Director at the time of discovery. | K 353 | | |