DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: MVY6

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	LETED BY T	THE STAT	IE STATE SURVEY AGENCY Facility ID: 00522					
MEDICARE/MEDICAID PROVII (L1)		3. NAME AND ADDRESS OF FACILITY (L3) ST ANTHONY HEALTH CENTER (L4) 3700 FOSS ROAD NORTHEAST (L5) ST ANTHONY, MN			(L6)	55421	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Survey Afte	9. Other er Complaint
6. DATE OF SURVEY 12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	22/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR END	ING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	150 (L18) 150 (L17)	Compliance1. A B. Not in Con		gram	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	The Following Requirer	ervices Limit rector om Size
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY M	MEETS		
18 SNF 18/19 SNF 150		ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REP	(L39) MARKS (IF APPLICA	(L42) ABLE SHOW LTC C	(L43) ANCELLATION	N DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:
<u>Ionathan Hill, HFE NE II</u>		1	/5/2016	(L19) K	a <u>mala Fiske-</u>	Downing, F	Inforcement Speci	ialist 1/5/2016 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OF	R SINGLE S	TATE AGENCY	
DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WIT HTS ACT:	H CIVIL	 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:	:	(L30)
OF PARTICIPATION 07/01/1984	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos		05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Invol		on	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		04-Other Reason	-	OTHER	der Status Change
(L27)	B. Rescind Su	uspension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVA	L DATE				
	(L32)			(L33)	DETERMIN	ATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245267

January 5, 2016

Ms. Mary Yaeger, Administrator St Anthony Health Center 3700 Foss Road Northeast St Anthony, MN 55421

Dear Ms. Yaeger:

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 3, 2015 the above facility is certified for:

150 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 150 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Electronically delivered January 5, 2016

Ms. Mary Yaeger, Administrator St Anthony Health Center 3700 Foss Road Northeast St Anthony, MN 55421

RE: Project Number \$5267027

Dear Ms. Yaeger:

On November 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 29, 2015. 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 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 16, 2015 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 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 3, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 29, 2015, effective December 3, 2015 and therefore remedies outlined in our letter to you dated November 20, 2015, 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.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Minnesota Department of Health Kamala. Fiske-Downing@state.mn.us

Kumala Fiske Downing

Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245267	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/22/2015
Name of Facility		Street Address, City, State, Zip Code	
ST ANTHONY HEALTH CENTER		3700 FOSS ROAD NORTHEAS	Т

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
ID Prefix Reg. # LSC	-	Correction Completed 12/03/2015 (iii)-(iii), (c)(2) -	ID Prefix Reg. # LSC	F0226 483.13(c)	Correction Completed 12/03/2015		F0241 483.15(a)		Correction Completed 12/03/2015
ID Prefix Reg. # LSC	F0246 483.15(e)(1)	Correction Completed 12/03/2015	ID Prefix		Correction Completed 12/03/2015 2)	ID Prefix Reg. # LSC	483.20(k)(3)(ii	i)	Correction Completed 12/03/2015
ID Prefix Reg. # LSC	F0315 483.25(d)	Correction Completed 12/03/2015	ID Prefix Reg. # LSC		Correction Completed 12/03/2015	ID Prefix Reg. # LSC	483.25(m)(1)		Correction Completed 12/03/2015
ID Prefix Reg. # LSC	F0333 483.25(m)(2	Correction Completed 12/03/2015	ID Prefix Reg. # LSC		Correction Completed 12/03/2015	ID Prefix Reg. # LSC			Correction Completed 12/03/2015
ID Prefix Reg. # LSC	F0425 483.60(a),(b	Correction Completed 12/03/2015	ID Prefix Reg. # LSC		Correction Completed 12/03/2015	ID Prefix Reg. # LSC	483.65		Correction Completed 12/03/2015
Reviewed I State Agen Reviewed I	су	Reviewed By GD/kfd Reviewed By	Date: 1/5/201 Date:	Signature of Sur Signature of Sur		25480		Date: 12/22 Date:	/2015
	o Survey Co 10/2	mpleted on: 29/2015		Check for any Unco Uncorrected Defic				YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245267	(Y2) Multiple Cons A. Building B. Wing	ostruction 01 - MAIN BUILDING 01		(Y3) Date of Revisit 12/16/2015
Name of Facility			Street Address, City, State, Zip Code	
ST ANTHONY HEALTH CENTER			3700 FOSS ROAD NORTHEAS	Т

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ST ANTHONY, MN 55421

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 12/03/2015	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #	NFPA 101		Reg. #			Reg. #		
LSC	K0046		LSC			LSC _		
		Correction			Correction			Correction
ID Profix		Completed	ID Profix		Completed	ID Profix		Completed
			Dog #					<u>—</u>
Reg. # LSC			Reg. # LSC			Reg. # LSC		
		Correction			Correction			Correction
ID D		Completed	ID Des fire		Completed	ID Des fire		Completed
					=			
Reg. # LSC			Reg. # LSC			Reg. # LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #			Reg. #		
LSC			LSC			LSC		<u> </u>
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #								
			LSC			LSC _		<u> </u>
Reviewed I		ewed By	Date:	Signature of Sur	-		Date:	
State Agen	,		1/5/2016	2720	00			12/16/201
Reviewed I	By Revie	ewed By	Date:	Signature of Sur	veyor:		Date:	
Followup t	o Survey Complete			Check for any Unco				
	10/29/20 ²	15		Uncorrected Defice	ciencies (CM	S-2567) Sent to the	e Facility? YES	NO



Electronically delivered

January 5, 2016

Ms. Mary Yaeger, Administrator St Anthony Health Center 3700 Foss Road Northeast St Anthony, MN 55421

Re: Reinspection Results - Project Number S5267027

Dear Ms. Yaeger:

On December 22, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 10, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

	State Form: Revisit Report							
(Y1)	Provider / Supplier / CLIA / Identification Number 00522	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/22/2015				
Nam	e of Facility		Street Address, City, State, Zip Code					
ST	ANTHONY HEALTH CENTER		3700 FOSS ROAD NORTHEAS ST ANTHONY, MN 55421	Т				

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) Item			(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	20565		Correction Completed 12/03/2015	ID Prefix	205	570	C	orrection ompleted 2/03/2015		ID Prefix	20910		Correction Completed 12/03/2015
	MN Rule 46		p. :			Rule 4658.0405		. 4			MN Rule 46		
Reg. #	20930 MN Rule 46	58.0525 Sub	p. i	Reg. #	MN	015 Rule 4658.0610	1:	orrection completed 2/03/2015		Reg.#	21390 MN Rule 46	58.0800 \$	Correction Completed 12/03/2015 Subp. 4
Reg. #	21426 MN St. State	ute 144A.04		Reg. #	MN	525 Rule 4658.1305	1:	orrection completed 2/03/2015		Reg.#	21545 MN Rule 46	58.1320 /	Correction Completed 12/03/2015 A.B.C
Reg. #	21610 MN Rule 46	58.1340 Sub		Reg. #	MN	735 Rule 4658.1420	1:	orrection completed 2/03/2015		Reg.#	21805 MN St. Statu	ıte 144.6	Correction Completed 12/03/2015 51 Sut
Reg. #	21810 MN St. State		Correction Completed 12/03/2015 Sut	Reg. #		980 St. Statute 626.	1	orrection completed 2/03/2015 ut		Reg.#	22000 MN St. Statu		Correction Completed 12/03/2015 557 Su
		ı											
Reviewed		Reviewed	Ву	Date:		Signature of		-				Date:	
Reviewed CMS RO	By ——	GD/kfd Reviewed	Ву	1/5/201 Date:	6	Signature of	5480 Surve					12/22 Date:	2/2015
Followup	Followup to Survey Completed on: 10/29/2015			Check for any Uncorrected Deficiencies. Uncorrected Deficiencies (CMS-2567)						NO ,			
STATE FOR			Page 1 of 1					Event ID:	MVY612	2			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: MVY6

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY TH						E STATE SURVEY AGENCY Facility ID: 00522			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245267 STATE VENDOR OR MEDICAID NO. (L2) 369742800		3. NAME AND ADDRESS OF FACILITY (L3) ST ANTHONY HEALTH CENTER (L4) 3700 FOSS ROAD NORTHEAST (L5) ST ANTHONY, MN			(L6)	55421	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation 7. On-Site Visit	ON: 2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other		
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Survey Aft			
6. DATE OF SURVEY 10/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	29/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENI 12/31	DING DATE: (L35)		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	150 (L18) 150 (L17)	Complianc1. A X B. Not in Con	nce With equirements e Based On: cceptable POC	ogram	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	The Following Require	ervices Limit irector om Size		
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY M	MEETS				
18 SNF 18/19 SNF 150	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)			
(L37) (L38) 16. STATE SURVEY AGENCY REM	(L39) MARKS (IF APPLICA	(L42) ABLE SHOW LTC C	(L43) ANCELLATION	N DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:		
Becky Wong., HFE NE II		1	1/30/2015	(L19) K	a <u>mala Fiske-</u>	Downing, E	Inforcement Spec	ialist 12/09/2015 (L20)		
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OF	R SINGLE S'	TATE AGENCY			
DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WIT HTS ACT:	H CIVIL	1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE!	MENT	26. TERMINA	TION ACTION:	:	(L30)		
OF PARTICIPATION 07/01/1984	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos		05-Fail to	NTARY Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involvent		on	Meet Agreement		
25. LTC EXTENSION DATE: (L27)	_	n of Admissions:	(L44)		04-Other Reason		OTHER	der Status Change e		
(221)	B. Rescind Su	uspension Date:	(L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS					
		03001								
	(L28)			(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVA	L DATE						
	(L32)			(L33)	DETERMIN	ATION APPI	ROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered November 20, 2015

Ms. Mary Yaeger, Administrator St Anthony Health Center 3700 Foss Road Northeast St Anthony, MN 55421

RE: Project Number S5267027

Dear Ms. Yaeger:

On October 29, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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 by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (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 8, 2015, 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 29, 2016 (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 29, 2016 (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:

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

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Riske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Electronically delivered December 11, 2015

Ms. Mary Yaeger, Administrator St Anthony Health Center 3700 Foss Road Northeast St Anthony, Minnesota 55421

Dear Ms. Yaeger:

RE: Complaint Investigation Number H5297069

Ms. Yaeger:

On November 20, 2015 we notifed you electronically via the ePOC system, of the October 29, 2015 survey results for both health and life safety code. Since posting the findings, we realized the above-mentioned complaint investigation had not been documented in the initial comments of the health CMS 2567 and State form.

We have reposted to the ePOC system the initial comments of both the Federal deficiencies and the State correction orders with language related to the complaint investigation number H5297069, which was found to be unsubstantiated.

If you have additional questions, don't hesitate in contacting me.

Sincerely,

Kamala Fiske-Downing, Enforcement Specialist Program Assurance Unit Licensing and Certification Program

PRINTED: 12/11/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED
		245267	B. WING			10/29/2015
	PROVIDER OR SUPPLIER HONY HEALTH CENTE	ER .		STREET ADDRESS, CITY, STATE 3700 FOSS ROAD NORTHEAS ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 000		of correction (POC) will serve	F0	00		
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report 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 to the State nurse aide registry or licensing authorities.					
F 225 SS=D			F 2	25		12/3/15
33=0						
ADODATOS	involving mistreatm including injuries of misappropriation of reported immediate facility and to other State law through e (including to the Sta	asure that all alleged violations tent, neglect, or abuse, in unknown source and it resident property are ally to the administrator of the officials in accordance with established procedures at e survey and certification	NATURE	TITLE		(X6) DATE

Electronically Signed 11/27/2015

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245267	B. WING _		10/29/2015	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI REGULATORY OR LSC IDENTIFYING INFORMATION) T/			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLÉTION	
F 225	violations are thoro prevent further pote investigation is in p The results of all into the administrator representative and accordance with St survey and certificate days of the incident	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported or his designated	F 22	5		
	by: Based on interview facility failed to enswere immediately rand State agency (reviewed for incider Findings include: R55 had a diagnosmuscle weakness, listed on the Face Sannual Minimum Daindicated R55 had and required extensbed mobility, dressi	Based on interview and document review, the acility failed to ensure bruises of unknown origin were immediately reported to the administrator and State agency (SA) for 1 of 4 residents (R55) eviewed for incidents.		St. Anthony Health Center (SAHC makes its best effort to operate in compliance with state and federal law. Nothing included plan of correction is an admission otherwise. SAHC has submitted this plan of correction order to comply with its regulatory obligation and does not waive any objections to the metorm of any allegations contained I Please note that SAHC may contest the merits form of any of the deficiency finding alleged below and may take reasonable steps to them. Please accept this plan of correction as SAHC's	full in this on in erits or nerein. and/or gs	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIED/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245267	B. WING _		10/	29/2015	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 225	to R55's left inner on noted the cause was (RN)-J assessed the 4/20/15. The bruise centimeters (cm) X located on the inner covering an area nowas unaware of hordirector of nursing (ED) were notified investigation initiated. During interview on stated she was not two days later, "we origin." The DON, ED and 4/20/15, two days a origin was discover. The facility Vulnera policy dated 10/200 reporters will imme administrator/exect facility shall report in Entry Point. The pounexplained injurie neglect, abuse in prepeated or malicio language toward a	Jurse (LPN)-F about a bruise pluteal area on 4/18/15. LPN-F as unknown. Registered nurse he bruise with RN-F on a was noted to be 11 6 cm, dark purple in color and raspect of the left buttock ear the coccyx and anus. R55 which the bruise occurred. The (DON) and executive director of incident on 4/20/15 and an ed. 110/29/15, at 1:28 p.m. DON asure why they were notified report injuries of unknown SA all were notified on after the bruise of unknown	F 22	1.Resident R55 expired. 2.The facility Vulnerable Adult At Prevention policy and procedure been reviewed. 3.The Administrator and DON at VAA education at Care Providers 11/17/15. 4.Staff have been re-educated of facility Vulnerable Adult Abuse Ppolicy and program. 5.The IDT will review each incide determine reportability and appropreventative measures are put in 6.The facility QA&A committee wall incidents monthly. 7.See also F226. 8.The Executive Director remain responsible for compliance with requirement, to ensure that all all violations involving mistreatment or abuse, including injuries of un source are reported immediately	ouse has tended s on the revention ent to opriate oplace. rill review sthis leged oplect, known		
F 226 SS=D	considered threater shall be reported.	ning" and financial exploitation P/IMPLMENT	F 22	6		12/3/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10/29/2015
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F 226	The facility must de policies and proced mistreatment, negle and misappropriation. This REQUIREMENT	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.	F 226		
	facility failed to imp policy for immediate and State Agency (violation regardings	ased on interview and document review, the illity failed to implement the abuse prevention icy for immediately notifying the administrator d State Agency (SA) regarding an alleged lation regardingbruises of unknown origin for 1 4 residents (R55) whose incidents were		 1.Resident R55 expired. 2.The facility Vulnerable Adult Abus Prevention policy and procedure habeen reviewed. 3.The Administrator and DON attendance VAA education at Care Providers or 11/17/15. 4.Staff have been re-educated on the facility Vulnerable Adult Abuse Prev 	ded n
	The facility Vulnera policy dated 10/06, will immediately repadministrator/exect facility shall report in Entry Point. The pounexplained injuries neglect, abuse in prepeated or maliciol language toward a treatment of a vulne considered threater shall be reported.	ative director and that the mmediately to the Common dicy further outlined that is, therapeutic error with injury, art defined as "the use of us oral, written or gestured vulnerable adult or the erable adult which could be ning" and financial exploitation		policy and program. 5.The IDT will review each incident determine reportability and appropri preventative measures are put in ple 6.The facility QA&A committee will rall incidents monthly. 7.See also F225. 8.The Executive Director remains responsible for compliance with this requirement, to ensure that the abust prevention policy is implemented.	to iate ace. review
	muscle weakness, listed on the Face S annual Minimum Da	es that included general dementia and depression Sheet dated 4/21/15. The ata Set dated 5/15/15, severe cognitive impairment			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIED/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245267	B. WING _		10/2	29/2015
	PROVIDER OR SUPPLIER	ĒR		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	An incident report of evening cares, nursilicensed practical into R55's left inner gnoted the cause was (RN)-J assessed the 4/20/15. The bruise centimeters (cm) X located on the inner covering an area now was unaware of hodirector of nursing of	sive assistance of two staff for ing, locomotion and toileting. Idated 4/20/15, indicated during sing assistant (NA)-I alerted turse (LPN)-F about a bruise gluteal area on 4/18/15. LPN-F as unknown. Registered nurse the bruise with RN-F on the was noted to be 11 6 cm, dark purple in color and or aspect of the left buttock the ear the coccyx and anus. R55 with the bruise occurred. The (DON) and exucutive director dent on 4/20/15. Investigation	F 22	6		
F 241 SS=E	stated she was not two days later, "we origin." The DON, ED and 4/20/15, two days a origin was discover 483.15(a) DIGNITY INDIVIDUALITY The facility must pr manner and in an enterest each rest full recognition of home	a 10/29/15, at 1:28 p.m. DON sure why they were notified report injuries of unknown SA all were notified on after the bruise of unknown red. AND RESPECT OF comote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality. NT is not met as evidenced tion, interview and document	F 24	1.Resident R289 has been discha	rged	12/3/15

	FEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLE					
		245267	B. WING		10/2	29/2015
	PROVIDER OR SUPPLIER	ER .	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRESE OF THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 241	residents (R43, R7 provided in a dignif Findings include: R43's diagnosis incataract, mild cogn Osteoporosis, mus depression and ost the Face Sheet dat R43's was observe The bedroom door and lights were out her backAt 7:11 a.m. R43 whow she had slept she was stiff and dior bad thing. R43 in left hand and shoul medication and to g-At 7:14 a.m. surve practical nurse (LP request to get up.	railed to ensure 4 of 5 7, R289, R291) cares were ied manner. cluded anxiety, glaucoma, itive impairment, cle weakness, major recoarthritis obtained from form red 10/29/15. d on 10/28/15, at 7:03 a.m. was observed door wide open ray as observed lying on when approached and asked R43 stated had slept well but id not know if that was a good adicated she had pain on her der and requested for pain	F 241	,	nent apdated ling for evey dignity/ the next ew the lentified amittee dations.	
	-At 7:34 a.m. upon assistant (NA)-D w bedside then went towel came back a wash her face. Privaround the bedAt 7:35 a.m. NA-E R43 was in her gro ready for the dayAt 7:36 a.m. to 7:3	entering R43's room nursing as observed standing at R43's to the bathroom got a wash and cued R43 she was going to racy curtain was not pulled entered the room indicated up and was going to get her as a.m. both NA's were R43's hospital gown and				

				E SURVEY PLETED		
		245267	B. WING _		10/	29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	back then pat dried NA-E then applied R43's breast expose-At 7:40 a.m. NA-D then completed per NA's cued R43 to rebottom. NA-D remonever washed her lidresser by the wall indicated the glove over to her right side out but never applied NA-E she was goin R43's wheelchair. Noutside the hallway NA-E was standing incontinent pad with and privacy curtain out and was able to standing in the hall NA-D then wheeled room shut the door adjust R43's pants going to assist her bed before transfer -At 7:42 a.m. NA-D shirt as R43 sat on -At 7:44 a.m. with bides NA-D applied waist then cued R4 and guided R43 to wheelchair. On 10/28/15, at 7:5 breast had not beet time cares were prosecution.	her upper body including the the area did not cover R43. socks and pants half way. Still ed. cued R43 to open her legs icare in the front. Then both oll as NA-D cleansed her oved the soiled gloves and hands, went over to the across from R43's bed and box was empty, then reached be scrubs pocket got one glove ed it. NA-D then indicated to goutside the room to get NA-D left the room went left the door wide open as at resident bed applying the in resident breast still exposed not pulled. Surveyor followed on see R43's entire body when way looking into the room. If R43's wheelchair into the Both NAs were observed then cued R43 they were to get seated at the edge of ring to the wheelchair. was observed apply R43's	F 24			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIED/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245267	B. WING _		10/	/29/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	pulled for privacy d wheelchair was bei NA-E stated "usual I don't have to leave been pulled." On 10/28/15, at 1:1 (RN)-F stated she was resident body expoand to cover a resident body expoand to cover a resident with like a to pull the privacy of the weather and supposed to pull the state of the weather and supposed to pull the privacy of the weather and supposed to pull the state of the weather and state of the state of the weather and state of the weather and state of the we	curtain was supposed to be uring cares and when ng brought into the room ly her cares go a lot faster and e the room. Yes it should have 1 p.m. registered nurse would expect staff to have a sed minimally during cares dent skin that was not being towel and staff was supposed curtain. 1 a.m. R43 was observed elchair at the dining room if it bother her when staff when receiving personal cares old I don't like people seeing 36 a.m. LPN-D nurse is a dignity thing we knock at we are providing cares staff ea they are not working on. cose residents and be mindful being cold. Staff are also e privacy curtain with cares all	F 24	,		
	(DON) stated she v	0 p.m. the director of nursing vould have expected staff to during cares. Acknowledged				
	Assessment (CAA)	ring (ADL's) Care Area dated 2/5/15, indicated R43 assistance with dressing				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

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		245267	B. WING _		10	/29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COD 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	Continued From pa	al hygiene.	F 24	1		
	feeding (TF) obtain Minimum Data Set	use of gastric tube (GT) (tube ed from the quarterly (MDS) dated 8/11/15.				
	observed set R77's -At 7:11 a.m. both L room to observe me gastrostomy tube (was going to admir Upon entering room eye closed and the approximately 20 d medication on the bathroom, obtained (measuring device) then disconnected end with alcohol har resident she was gothen after administed During the entire of open and the private length of the rooms -At 7:16 a.m. R77's	LPN-A and surveyor went to edication administration via GT). LPN-A stated to R77 she hister morning medications. In, R77 was lying on her back, head of bed was at egrees. LPN-A set the bedside pull table went to the lawater in a cylinder and applied gloves. LPN-A the tube feeding cleansed the lang it up on the pool. Stated to be one to listen to her stomach ered medications via GT. Deservation time door was wide by curtain was pulled to the				
	there briefly then w walked past R77's the shared bathroo medications. On 10/29/15, at 12: she had neither clo privacy curtain duri	ent over to the dresser and area/space as she went into m. LPN-A still administering 07 p.m. LPN-A acknowledged sed the door nor pulled the ng the procedure. LPN-A sed to have been done to				

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F 241	stated, "If the reside have expected the and pulled the prival on 10/29/15, at 1:3 requested but the do not have a digniresident rights." R289's admission M289 was severely required assistance indicated R289 was bowel and bladder. diagnosis of demer Continuous observal. a.m. until 10:47 a.m7:06 a.m. Residem -7:38 a.m. Nursing R289's room and straightful and NA-A retraightful and NA-A retraightful and encouraged R2"I am afraid." NA-C explain staff were hand encouraged R2 wash R289's bottor and just held NA-C -7:51 a.m. NA-A an tell the nurse R289	9 p.m. the director of nursing ent was exposed she would nurse to have shut the door acy curtain." 4 p.m. a dignity policy was irector of nursing stated "We ty policy. We follow the MDS dated 10/23/15, indicated cognitively impaired and with all ADLs. R289's MDS a frequently incontinent of R289's MDS included that and depression. ation on 10/28/15, from 7:06 in the was sleeping in room. assistant (NA)-A entered stated it was time to get up. It to get help. urned to R289's room. ocked on the door and ithout waiting for the wasted a soothing voice to ere to help R289 get dressed 289 to roll over so NA-A could in. R289 would not turn over	F 24			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

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		245267	B. WING			10/2	9/2015
	PROVIDER OR SUPPLIER	ER .	•	STREET ADDRESS, CITY, STATE, 3700 FOSS ROAD NORTHEAS ST ANTHONY, MN 55421			
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F 241	assistance when re R289 lying in bed of face appeared district trembling. clutching am so frightened." I socks and black slaup legs. Incontinent R289's buttocks8:09 a.m. Residen hand clenched on selected and clenched on selected and the sele	ady to get up and left room. overed with a sheet. R289's ressed, eyes narrowed, lips top of sheet. R289 stated "I Resident had on red anti slip acks that were partially pulled ce pad was open under trying on bed staring at ceiling sheets. d NA-B entered R289's room IA-A and NA-B informed R289 to get R289 up for breakfast. B, "The nurse said she will get led R289 a wash cloth and o wash face and praised tood job. R289 refused to have. NA-A said over R289's head,		241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

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		245267	B. WING _		10	/29/2015
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F 241	for a response beforestated she would not resident comments. R291's Face Sheet R291 diagnoses incommunicating) and Sheet printed 10/28 R291's blood sugar. During a blood sugar. Explained the procest glucometer (a mack sugars) bucket down without a barrier beto the bed table. LPN-the water off. LPN-the water off. LPN-PDI wipe and allow LPN-B put on clear with an alcohol wipfinger, wiped off the drop of blood on teglucometer down of glucometer with PD wrapped glucometer the bucket. LPN-B hands, turning off face.	pected staff to knock and wait bre entering a room. The DON of expect staff to roll head at a printed 10/29/15, indicated cluded aphasia (difficulty dispersional	F 24	,		
	afford R291 privacy	acy curtain was not pulled to /. 43 p.m. R291 said, "I wish he				
			1			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED		
		245267	B. WING			10/2	29/2015
	PROVIDER OR SUPPLIER	ER .		37	REET ADDRESS, CITY, STATE, ZIP CODE 700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 246 SS=D	During interview on acknowledged, "I d checking the blood The facility's Our Pl form undated direct treat residents with 483.15(e)(1) REAS OF NEEDS/PREFE A resident has the reservices in the facil accommodations of preferences, excep	10/29/15, at 4:45 p.m. LPN-B id not shut the door while sugar. I should have." atinum Service Standards and dignity and respect. ONABLE ACCOMMODATION ERENCES	F 2	241			12/3/15
	by: Based on observative review, the facility faccessible for 1 of 3 incontinence and with call light. Findings include: On 10/27/15, at 9:5 observation the call on the other side of Both registered nur the call light was not -At 10:00 a.m. whee the call light R77 shasked to demonstrate	NT is not met as evidenced tion, interview and document ailed to ensure call lights were 3 residents (R77) reviewed for the were capable of using the 8 a.m. during R77 room I light was observed on floor bed not accessible to R77. se (RN)-K and RN-L verified at at reach. In asked if she was able to use nook her head and when ate R77 was not able to put the cord was wrapped up with			1.Resident R77 care plans and NAF assignment sheets have been review and updated as needed. 2.Staff will be re-trained on providing resident accommodation of needs, uspecific survey examples cited in the 2567. 3.Facility leadership will complete calight placement audits 2x/week until next QA&A meeting 12/15/15. 4.The Director of Nursing will review completed audits and bring any iden concerns to the facility QA&A commit for review and further recommendati 5.The Executive Director remains responsible for compliance with this requirement to ensure residents are	yed g for using e all the the tiffied ittee ions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			E SURVEY PLETED				
		245267	B. WING			10/:	29/2015
	PROVIDER OR SUPPLIER	ER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246 F 280 SS=D	her call light. On 10/29/15, at 2:5 stated the call light for all residents who R77's diagnoses in general muscle we mild cognitive impapalan report dated 1' R77's care plan for R77 at risk for fall a with neck injury. The keep "Call light with enabler bar." In add "Resident has also light for assistance verbalized understated understated but was 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated underparticipate in plannic changes in care and A comprehensive cassinterdisciplinary teaphysician, a register.	made it hard for her to use 9 p.m. the director of nursing was supposed to be at reach of were capable of using it. cluded abnormality of gait, akness, major depression and irment obtained from the care 1/6/15. falls dated 11/6/15, identified is evidenced by history of fall e care plan directed staff to hin reach [left] (L) side bed dition the care plan indicated been reminded to use her call with any needs and she anding to the counsel." 10 p.m. the call light policy was not provided. 10 (k)(2) RIGHT TO 11 NNING CARE-REVISE CP 12 eright, unless adjudged erwise found to be referenced to use the laws of the State, to ng care and treatment or	F 2		provided services with reasonable accommodation of individual needs	3.	12/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245267	B. WING			10/2	29/2015
	PROVIDER OR SUPPLIER	ER .		3700 F	ET ADDRESS, CITY, STATE, ZIP CODE FOSS ROAD NORTHEAST NTHONY, MN 55421	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	disciplines as deter needs, and, to the oparticipation of the or the resident's leg periodically reviewe	ge 14 mined by the resident's extent practicable, the resident, the resident's family gal representative; and ed and revised by a team of fter each assessment.	F 2	80			
	by: Based on observatoreview, the facility for care was revised for included keeping the prevent aspiration of feedings. Findings include: On 10/27/15, at 9:5 be in bed, with the bed raised only about feeding (TF) was be (GT). On 10/27/15, at 11: observed to be lying elevated more than was observed to be per hour via GT. On 10/28/15, at 7:4 in bed. R77 was lying the bed. R77's he foot partially off bed.	ion, interview and document ailed to ensure the plan of ir 1 of 1 resident (R77) which e head of bed elevated to during continuous tube 8 a.m. R77 was observed to head of bed (HOB) head of out 10 degrees while a tube being infused via gastric tube 30 a.m., R77 was again g in bed without the HOB 10 degrees. A tube feeding a running at 70 milliliters (ml's) 5 a.m. R77 appeared asleeping on back, but was crooked ead was toward wall and left and the lower extremities the HOB approximately 10		refee 2. tull refee 3. ed 11 4.1 co 5 be we 6. co refer 7 8. refee ca	Resident R77 care plans have be viewed and revised with enteral teding information as needed. The care plans of all other reside be feedings have been reviewed vised as needed. The Nursing Leadership team reducation on auditing care plans of /19/15. Nursing staff will be educated on ompletion and updating of care plans as ecompleted by nursing leadership eekly until the next QA&A 12/15/2 The facility QA&A committee will ompleted audit results and make commendations. See also F322. The Director of Nursing remains sponsible for compliance with this quirement, to ensure comprehentate plans are developed to meet sident needs.	the ans. dit will p 15. review further	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10/	29/2015	
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE	
F 280	running at 70 ml's/r-At 9:30 a.m. staff or R77, when staff en nurse (RN)-G immediated when as elevated when the should be at 45 degrees upon enterentire time LPN-A or LPN-A never elevar procedure, R77 applicated diagnoses of dysphishes, fracture of the weakness, use of greeding (TF) directly inserted through the (blood clot affecting respiratory failure. R77's Care Plan daindicated: Problem areas: "Nu aspiration risk, etc. feeding, and Need seizures and dysphish for enteral feeding included: "Resident date of 1/27/16)" I	n, with the TF attached and nr. were prompted to observe tered the room, registered ediately elevated the HOB, sked "the HOB should be tube feeding was running, grees." 7:01 to 7:04 a.m., during stration with licensed practical HOB was observed at 20 ring the room and during the was administering medication. ted the HOB during the peared to be asleep with eyes	F 2	280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
245267		B. WING			10/29/2015		
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 280	Adjustments will be resident to decreas MD [medical docto orders (thick liquids observed by staff a fluids; NPO [nothin 5/17/15; oral care of feeding- continue to labs per facility pro appropriate; SLP [S swallow clarification via cup sip if sitting small sips and chin (water) as ordered identified the tube finterventions to dire of the bed during the high the HOB shown aspiration, nor was care plan that the r	referrals will be made; e made in the care of the se the risk of aspiration; Notify of and obtain appropriate se, etc.) Resident to be to meals and when taking go by mouth] last updated every 2 hours; GT tube to monitor intake, weights and tocol and intervene when speech Language Pathology] on Ok for nectar thick liquids upright and supervised. Use tuck; Provide TF and H20. Hathough the care plan seeding use, there were no ect staff related to the position on GT feeding such as, how lid be to prevent potential there any indication on the esident refused any treatment HOB elevated, due to	F 28	0			
	lying in bed uncover TF was running at LPN-A was brough R77, and verified the LPN-A elevated the listened the resider were clear." - At 11:11 a.m. RN-always be between risk of aspiration. - At 2:17 pm the direct the resider was been between the resider was between the resider was between the second s	46 a.m. R77 was dressed and ered, the HOB was flat and the red, the HOB was flat and the room in the room to observe the HOB should not be flat, and the HOB to 30 degrees. LPN-A and lungs and stated the "lungs". B stated the HOB should a 45 to 90 degrees to prevent rector of nursing (DON) stated elevated as much as es, the DON verified best					

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		245267	B. WING		10/29/2015	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLÉTION	
	practice would be to minimum 30 degree. The facility policy for 7/23/13, directed st 4. "Resident's with must have their HO times." The American Socion Nutrition, Special R 27, 2009, indicated research-based evirecommend HOB eprevent aspiration at 483.20(k)(3)(ii) SEPPERSONS/PER CATTHE SERVICES provious be provided by accordance with eacare. This REQUIREMENT by: Based on observatoreview, facility failed	The American Society for Parenteral and Enteral Nutrition, Special Report published in January 27, 2009, indicated, "In summary, based on research-based evidence, authorities recommend HOB elevation of 30° - 45° to prevent aspiration and pneumonia." 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced		1.Resident R289 no longer reside facility. 2.Other residents will have their Tocare plans updated with each qual annual, or significant change of composition.	oileting irterly,	
	R289 had an altera function and instruc	ort dated 10/28/15, instructed tion in bowel and bladder sted staff to toilet the resident and after meals, with night		3.Staff will be in-serviced on follow care plan interventions/NAR assignsheets and toileting schedules us specific survey findings as an exa 4.Nursing leadership will complete toileting audits 2x/week until the name of the services of the	gnment ing mple. e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING			10/2	29/2015
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CENTER				3	TREET ADDRESS, CITY, STATE, ZIP CODE 700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	rounds and as need and change every (The nursing assists sheet indicated R28 Resident Care Sumundated instructed 2hr" copy requested. Continuous observationa. Residen -7:42 a.m. Residen -7:42 a.m. Nursing R289 that they were and get dressed. Nand attempted to we -7:51 a.m. NA-A and would tell the nurse up. NA-A instructed for assistance where room. R289 lying in The resident had on slacks that were pallicontinent pad ware -8:00 a.m. registered R289. R289 agreed -8:22 a.m. NA-A and they were here to ge -8:40 a.m. NA-A and they were here to ge -8:40 a.m. R289 on -9:21 a.m. R289 on -9:21 a.m. R289 bronursing station. -10:28 a.m. Activities -10:42 a.m. Reside Place. -10:47 a.m. Church	ded. R289 was to be checked (Q) two hours (hrs). ant (NA) undated assignment as incontinent of bladder. In a property of the continent of bladder. In a property of the continent of bladder. In a property of the continent of care (POC) staff "Check and change Q do but not received. ation on 10/28/15, from 7:06 in noted the following: the was sleeping in room. In assistant (NA)-A explained to be going to help R289 get up in A-A opened incontinent brief ash R289 up. In a property of the continent brief ash R289 up. In the continent brief ash R289 to use call light to call in ready to get up and left in bed covered with a sheet. In red antificially pulled up legs. In red antificially pulled up legs. In the continent brief as open under R289's buttocks. In the continent brief and NA-B informed R289 that the the R289 up for breakfast. In the the R289 up for breakfast. In the R289 up for breakfast.	F 2	282	QA&A meeting on 12/15/15. 5.The facility QA&A committee will completed audit results and make recommendations. 6.The Director of Nursing remains responsible for compliance with this requirement, to ensure that resider receive the appropriate treatment as services to improve/maintain ADLS.	further s nts and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245267	B. WING		10/29/2015		
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CENTER				3	TREET ADDRESS, CITY, STATE, ZIP CODE 700 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 282 F 315 SS=D	R289 was back on where on way back bathroom while at of to desk11:50 a.m. R289 tapad checked. R289 During interview on Activities staff-A stabefore I took R289 During interview on stated, "After [R289 and now she is back breakfast. I have not breakfast. I have not breakfast. I have not check and change buring interview on RN-C stated I would expect the stand would expect the stand would expect the stand change buring interview on director of nurses (to follow check and plan of care. 483.25(d) NO CATI RESTORE BLADD Based on the residuassessment, the faresident who entersindwelling catheter resident's clinical control of the standard control of the standard catheter resident's clinical control of the standard catheter resident's clinical control of the standard catheter resident's clinical catheter resident's cli	unit. R289 did not stop any and R289 did not go to the church. R289 was seated next asken to room and incontinent asken to the staff know off the unit." 10/28/15, at 10:45 a.m. 10/28/15, at 11:41 a.m. NA-A and a late [R289] went to the staff to toileted R289 yet." 10/28/15, at 12:25 p.m. 10/28/15, at 12:25 p.m. 10/28/15, at 12:25 p.m. 10/29/15, at 2:35 p.m.		282			12/3/15
	catheterization was	necessary; and a resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245267		B. WING		10/29/2015		
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 8700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	This REQUIREMEI by: Based on observareview, the facility freassess and proviservices for 1 of 2 phad an indwelling Fube inserted into the can be left in place Findings include: During observation was observed to had rainage bag contathat time, R24 state in place for six mornhad to go to the hood R24's current care indicated R24 had in urinary eliminatic evidenced by Foley antibiotic medication [urinary tract infectification of the condary to renal secondary to re	ons and to restore as much ction as possible. NT is not met as evidenced tion, interview and document ailed to comprehensively de appropriate care and catients (R24) reviewed who foley catheter (a thin, sterile ne bladder to drain urine which for a period of time). on 10/28/15, at 3:43 p.m. R24 ave a Foley catheter tube and aining clear yellow urine. At ed he'd had the Foley catheter and had recently spital to have it changed. plan printed on 10/28/15, problems including: "alteration on related to diabetic as a catheter in use and history of an for a diagnosis of UTI on]" and "Indwelling catheter nary retention with obstruction failure.	F 315		en theter ext is review further is sits	
	5/5/15, indicated R an indwelling Foley indicated staff had catheter, but R24 h	sion Clinical Note dated 24 had been readmitted with catheter. A note from 5/8/15, been going to remove the lad "requested to have the corrow morning (5/9/15)." The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CTION IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	245267 B. WING			10/	29/2015		
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 315	Clinical Notes indiciplace until 9/29/15, attempted (unsuccess was ordered to have during morning shiff "Writer tried two tim 16 F [French, a unit but was unsuccess then ordered a Coutip that maneuvers the bladder], which had originally been May. "Writer, with the nurse manager tries complete task. NP ER [emergency root unsuccessful. [R24 but declined at this been voiding now'. output throughout sintervene as appropriate tried two tim 16 F catheter but wordered a Coude' ti that maneuvers are the bladder] which the hospital. Writer another floor nurse yet unable to comp send resident to EF evaluation if unsuccessful in the sender of the se	ated the catheter remained in when a nurse removed and essfully) to reinsert it. dated 9/29/15, indicated R24 e indwelling catheter changed it due to risk for infection. The set of insert new Foley using a set of measurement] catheter ful. NP [nurse practitioner] and it it is foley catheter [a bent around obstructions leading to was the type of catheter that inserted in the hospital in the assistance of another floor defined the procedure, yet unable to gave order to send resident to sem for further evaluation if informed with above order time. Resident stated 'I have Nursing monitoring [R24's] shift for possible retention and	F 31	5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245267	B. WING			10/2	29/2015
	PROVIDER OR SUPPLIER	ER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	stated 'I have been monitoring [R24's] opossible retention a On 9/30/15, the Clin "was monitored all centimeters] yellow infection." Another included: "without Foutput, 0 cc bladde residual]. R24 askir time. Daily schedule information, was inf Clinical notes from hospital appointmen on appointment at tupdate regarding of from yesterday. [R2 whatever she said I put catheter in right updated on output a okay to send to ER request." The notes the hospital 10/1/15 insertion. The hospital Dischar R24 had been sent indwelling catheter culture completed was antibiotics had be A Clinical Note entrindicated the reside facility: "Foley intac was started on Cipr days for UTI." The I	yoiding now'. Nursing putput throughout shift for and intervene as appropriate." Inical Notes indicated R24 might, voided 350 cc [cubic color, no signs/symptoms of Clinical Note from 9/30/15 foley catheter. Had 750 cc r scan PVR [post voiding for tomorrow's appointment ormed will update tomorrow." 10/1/15, indicated: "today's not was to put catheter in, told this time, writer to call NP to utput and bladder scan result example and bladder scan yesterday, to put catheter in per [R24] is indicated R24 was sent to be an own, you hear me', NP and bladder scan yesterday, to put catheter in per [R24] is indicated R24 was sent to be at 10:15 a.m. for catheter arge Summary Note indicated to the hospital 10/1/15 for an replacement and had urine which was positive for a UTI, een initiated for R24. By dated 10/2/15, at 3:55 p.m. and thad arrived back at the toutput 800 cc, urine yellow, to 500 milligrams [mg] x 7 motes also indicated R24 had a related to the Foley	F3	315			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		245267	B. WING			10/2	29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZI 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 315	including; to be see catheter replacement to monitor for signs adjust per resident. Further review of R any indication that changed from 5/5/1 physician and nurse 5/7/15 through 10/1 notes did not addreprior to his hospital replacement and in Physician Order Shany direction for state treatment of the incompart of the induction of catheter, balloon symptoms to monit the indwelling cathet. The facility's form, I dated 5/10/15, indicated 5/10/15,	en by urology monthly for ent, and for nursing to continue /symptoms of infection and s needs. 24's medical record lacked the catheter had been 5 to 9/29/15. In addition, e practitioner notes from 1/15, were reviewed. Their ess the indwelling catheter ization for catheter fection. In addition, the neets prior to 10/2/15, lacked aff to provide care and dwelling catheter such as; size size, what signs and or for, and when to replace eter. Bowel and Bladder Evaluation catheter placed. This d R24 was at risk for being immobile, and was don two staff for transfers. The address diagnoses which discontinence, i.e, kidney ongestive heart failure) which at the time of admission per scharge documents. The not include a review of build affect kidney dysfunction	F3	315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245267	B. WING _		10	/29/2015
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CO 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 315	included on the Ma Sheet. Although B indicated a trial per been done with no documentation on Clinical notes to inchad been attempte catheter 9/29/15. Owas a section identifying need for output, diagnoses sulcers, terminal illumovement with intrurethral blockage of (documented by Pand staff unable to catheterization (thr section of the Boweindicated residents should meet at least conditions, however Finally, the Evaluat removal plan, or risfrom the use of a coblockage, bypassin bleeding or expulsion A quarterly Minimu 7/10/15, indicated I diabetes, renal instituted by 100 more proposed in the section of the Boweindicated residents should meet at least conditions, however Finally, the Evaluate removal plan, or risfrom the use of a coblockage, bypassin bleeding or expulsional plan or expulsional p	these medications were y 2015 Physician Order owel and Bladder Evaluation iod of urinary retraining had improvement, there was not the Evaluation, nor in the dicate when such retraining d prior to the removal of the on the Evaluation form there diffied as: Evaluation For welling Catheters. This dications for a Foley such as: exact measurement of urine such as unstageable pressure ess, severe impairment and actable pain, or untreatable ausing urinary retention and ladder Evaluation form with indwelling catheters. This el and Bladder Evaluation form with indwelling catheters at one of the identified or R24 did not meet any. In ion form failed to indicate any of the indicate any of the identified atheres such as infection, and urine, pain, discomfort,	F 31	5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	bladder with Foley evaluation revealed prior form complete R24 was at risk for immobile, and was poor decisions, and staff for transfers. It R24 had antianxiety lorazepam), and a (Oxycontin, morphi PRN) as indicated Physician Order Shoet post 1 R24 seen by the ur catheter change du Evaluation form rer R24 diagnoses and plan or risks/compli of a catheter such a bypassing urine, paexpulsion. On 10/29/15, at 9:0 (RN)-F was intervise catheter had been further verified the reinsert a catheter output, and had up R24 had been sent replacement on 10/She further verified the facility, he had catheter replacement there had not previous prior form the sent replacement on the further verified the facility, he had catheter replacement there had not previous prior form complete.	dicated R24 was continent of catheter placed. The datheter placed. The datheter same outcome as the ed 5/5/15, with this exception: incontinence due to being cognitively impaired - made days dependent upon two an addition, the form indicated	F 31	5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		COMPLETED	
		245267	B. WING _		10	/29/2015
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	On 10/29/15, at 2:4 (DON) stated she vand that he'd refuse DON said the staff but stated she (the the facility had doct catheter in or changhave gotten some to kept the Foley in. Taware R24 had gor have his catheter catheter had been procedure. The DOC catheter, and would the catheter change On 10/29/15, at 3:1 normal protocol was changed monthly, RN-F explained it was admitted with a would obtain orders time would look for it was medically ne for catheter care she when to change the was new in her role September 2015. The Care Delivery dated 7/31/12, indicindwelling catheter be assessed for ap catheter information along with the reas residents with cathemonitoring and doctors.	A p.m. the director of nursing was aware R24 had a catheter, ed to let staff take it out. The had routinely updated the NP, DON), was unaware whether umented orders to keep the ge it, and verified they should type of orders since R24 had he DON also stated she was ne to the hospital on 10/1/15 to hanged. She stated his reinserted in a surgical N also said R24 wanted the d now go in every month to get		5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED	
		245267	B. WING			10/29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, ST 3700 FOSS ROAD NORTH ST ANTHONY, MN 554	IEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA CICIENCY)	
F 315	would be changed a days based on their Although the policy catheter, R24 lacker indwelling catheter assessment as to have changed. 483.25(g)(2) NG TRESTORE EATING Based on the compresident, the facility (1) A resident who have alone or with assist gastric tube unless condition demonstrative was unavoidal (2) A resident who is gastrostomy tube retreatment and service pneumonia, diarrhemetabolic abnormal	more or less than every 30 r assessment. directed to assess the ed a re-assessment of the and did not have an low often the catheter should REATMENT/SERVICES - SKILLS brehensive assessment of a r must ensure that has been able to eat enough ance is not fed by naso the resident 's clinical ates that use of a naso gastric	F3			12/3/15
	by: Based on observat review, the facility for	NT is not met as evidenced tion, interview and document ailed to ensure care and ided to prevent aspiration for 1		1.Staff were inserv Tube Feeding Polic elevated, as soon a	y including HOB	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245267	B. WING _		10/2	29/2015
	PROVIDER OR SUPPLIER	:R		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 322	of 1 resident (R77) feedings. Finding include: On 10/27/15, at 9:5 be in bed, with the about 10 degrees wheing infused via garden of the second of the sec	8 a.m. R77 was observed to HOB (head of bed) raised only while a tube feeding (TF) was astric tube (GT). 30 a.m., R77 was again g in bed without the HOB 10 degrees while the tube	F 32	concern during the annual survey 2.R77 Nutrition and Bed mobility plans have been reviewed and up as needed. 3.Other residents with Enteral tult feedings have had their Nutrition mobility care plans reviewed and as needed. 4.The facility Enteral Tube feeding policies have been reviewed and appropriate. 5.Staff will be in-serviced on the Tube feeding Policy. 6.Nursing leadership will complet mobility/HOB audits on all reside enteral tube feeding 2x/week unt next QA&A committee meeting 1. 7.The facility QA&A committee w completed audit results and make recommendations. 8.See also F280. 9.The Director of Nursing and Die remain responsible for compliance this requirement, to ensure that receiving gastrostomy feedings rethe appropriate treatment and see	care podated pe and bed revised g remain Enteral te bed nts with fil the 2/15/15. ill review te further etician te with te sidents te ceive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245267	B. WING			10/2	29/2015
	PROVIDER OR SUPPLIER	ER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 700 FOSS ROAD NORTHEAST T ANTHONY, MN 55421	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 322	verified the HOB shaproceeded to eleval LPN-A then listened stated, "lungs are continued." R77's admission rehad been admitted diagnoses of dysphase, fracture of continued weakness, use of color affecting lungs/failure. R77's current Care included problem a (eating, aspiration roube feeding, and Novelated to seizures by need for enteral The goals included: "Resident when taking fluids; made; Adjustments the resident to decrive Notify MD [medical appropriate orders be observed by state fluids; NPO [nothing 5/17/15; oral care effeeding-continue to labs per facility profit appropriate; SLP [Signal sips and chin (water) as ordered.	ould not be flat, and te the HOB to 30 degrees. d to the resident's lungs and	F3	322			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X	(3) DATE SURVEY COMPLETED
		245267	B. WING			10/29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIA	
F 322	of the bed during the high the HOB should aspiration. An admission Caredated 3/30/14, indiccognitive loss with a committed to stay a indicated R77 had overall activities of to assist with daily assessed to have a staff assistance with Status and Feeding had advised R77 restube feeding was beresident that HOB and TF is running to predict the trube feeding was the continuous tube assessment for direction. The MDS dated 8/6 assessments dated the tube feeding, but direction for staff at the elevated to prevent the NA care sheet to indicate direction.	ect staff related to the position are GT feeding such as, how and be to prevent potential. Area Assessment (CAA) cated R77 experienced delusions and had been court at the facility. The CAA experienced a deterioration in daily living and required staff cares. Although the R77 was cognitive loss, and required h daily care, the Nutritional at Tube CAA, indicated staff egarding positioning when the eing infused, "advised needs to be 45 degrees while	F3	322		

	ND DLAN OF CORRECTION INTERPRETATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING			10/2	29/2015
	PROVIDER OR SUPPLIER	ĒR		3	TREET ADDRESS, CITY, STATE, ZIP CODE 700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 322 F 332 SS=D	should always be be prevent risk of aspire on 10/29/15 at 2:1 (DON) stated the Hodgrees as much at that best practice welevated at a minima aspiration. The facility's policy dated 7/23/13, dired. "Resident's with must have their HOd times." The American Soci Nutrition, Special Resident's with must have their HOd times." The American Soci Nutrition, Special Research-based ever ecommend HOB expiration and pnerimplement standard failed to follow facil precautions for tuben Although a call was Medical Doctor for call. 483.25(m)(1) FREE RATES OF 5% OR	11 a.m. RN-B stated the HOB between 45-90 degrees to ration. 7 p.m., the director of nursing IOB should be elevated to 45 as tolerated. The DON stated would be to have the HOB num 30 degrees to prevent for Tube Feeding-Enteral cted staff: continuous enteral feeding OB 30 to 45 degrees at all ety for Parenteral and Enteral deport published in January, "In summary, based on idence, authorities elevation of 30°- 45° to prevent sumonia." The facility failed to do for care precautions, and ity policy related to aspiration to efeeding. Seplaced to R77's Primary comment, there was no return	F3				12/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245267	B. WING		10/29/2	015
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	(X5) IPLETION DATE
F 332	This REQUIREMENT by: Based on observator review, the facility for residents (R145) will device observed for was free of medicar error rate was at 79. Findings include: R145's Physician's indicated R145 had (Lantus Solostar 15 times daily for diaborated R145 had (Lantus Solostar 15 times daily for diaborated R145 had (RN)-H was observed open the cart obtained a Lantook the cap off obtained a Lantook the cap off obtained it to the cleansing the rubber insulin never primer of insulin never primer of insulin to pre-fill the cleanse the right low then punched the amotion gave the insulin gave the insulin rever priming cleanse the right low then punched the amotion gave the insulin rever priming. I will check on 10/27/15, at 8:3	ion, interview, and document ailed to ensure 1 of 4 ho utilized insulin FlexPen redication administration tion errors. The medication errors. The medication errors. The medication ion errors attended to the form of Glargine insuling units) subcutaneous two etes type II. 9 p.m. registered nurse ed set up R145's bedtime githe set up RN-H was top draw of the medication tus Solostar Flexpen for R145 ained an AutoShield from a extop of the FlexPen without er seal, dialed 15 units of did the FlexPen with two units the needle. Went to R145's room and oral medication was observed wer abdomen area let air dry rea and using constant firm sulin. asked what the facility policy insulin pens RN-H stated did here I was never told about	F 332	1.Staff were in-serviced on the Sol Insulin pen as soon as notified abor concern during the annual survey. 2.Resident R145 Insulin orders have been reviewed. 3.All residents with an order for an Flex pen have had their physician or reviewed. 4.PharMerica Nurse Consultant will conduct a medication administration in-service on 11/19/15. 5.Staff will be in-serviced on medicadministration, including Insulin flet 6.Nursing leadership will complete Flex Pens audits 2x/week until the QA&A meeting on 12/15/15. 7.The facility QA&A committee will completed audits and medication ereports monthly and make further recommendations. 8.See also F333. 9.The Director of Nursing remains responsible to ensure that the facilities of medication error rates of 5% greater.	ut the /e Insulin orders In ation x pens. Insulin next review error	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10)/29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZI 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 332	Solostar insulin for a pair of gloves ope the rubber seal of the AutoShield on then insulin. As LPN-E wadminister insulin s LPN-E what were the for priming the insulin ever primed the Formation of the cart went over to the heard ask RN-F wadming the conversal and asked what surpen. At 8:35 a.m. RN-Formation of the cart and nurses were just amount of insulin of the cart and nurses were supportes identification of the cart and nurses were supported and ordered amount." What 8:48 a.m. the diffication of the cart and pen I would expect ordered amount." What priming was Ewhat you mean." At 8:58 p.m. DON known the Flexpen and provided manuflexPen which indications the present of the cart and provided manuflexPen which indications then after the cart and provided manuflexPen which indications then after the cart and provided manuflexPen which indications then after the cart and provided manuflexPen which indications then after the cart and provided manuflexPen which indications then after the cart and provided manuflexPen which indications then after the cart and provided manuflexPen which indications the provided manuflexPen which i	R145 took off the cap donned ened the alcohol wrap wiped he FlexPen applied the dialed the pen to 15 units of was going into R145's room to urveyor intervened, asked of he manufacturer instructions lin pen, LPN-E stated she had lexPen before. LPN-E left the enursing station and was nat the instructions were and ation RN-F appeared confused reveyor meant by priming the nurse manager stated usually st supposed to dial to the redered for the resident. You and both nurses walked draw-F repeated to surveyor sed to dial to the amount ed. When asked what the actions were again RN-F and out from the pharmacist. The rector of nursing (DON) stated what you mean by priming the the nurses to dial up the when surveyor was explaining DON then stated "I now know stated all nurses should have was supposed to be primed affacturer instructions for the cated the device was e-filled with two units. Was observed give LPN-E ter LPN-E completed the correctly with DON and	F3	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10	10/29/2015	
	ROVIDER OR SUPPLIER ONY HEALTH CENTE	ER		STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	he did not administe answer to it. When expected 12 units to agreed and added be any harm if they On 10/29/15, at 3:3 consultant pharmacon prime the pens acconstructions when to nurses were supported two units of insuling dialing the ordered. The package insert March 2007 from Some directed staff to: "Step 3. Perform a Always perform the injection. Performing you get an accurate ensuring that pensiven removing air bubble. Select a dose of selector. B. Take off the outer remove the used not the inner needle can can be c	6 p.m. medical director stated er medications and would not asked if he would have be be delivered as ordered MD "if you're asking if there would got 10 or 14 units, no." 0 p.m. via phone the cist (CP) stated "They should ording to the manufacturer 's the CP was asked if the sed to prime the pens with to pre-fill the syringe prior to amount. for Lantus Solostar dated anofi-Aventis U.S. LLC Safety test Safety test before each g the safety test ensures that e dose by: and needle work properly es 2 units by turning the dosage or needle cap and keep it to be edle after injection. Take off p and discard it. In the needle pointing the safety test ensures that each cap and seep it to be edle after injection. Take off p and discard it. In the needle pointing the safety test several errorm the safety test several errorm the safety test several	F3	32			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10/2	29/2015
	PROVIDER OR SUPPLIER HONY HEALTH CENTE	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333 SS=D	If no insulin comes and repeat the safe remove them. If still no insulin coblocked. Change the lif no insulin comes needle, your SoloS use this SoloStar." 483.25(m)(2) RESI SIGNIFICANT MED The facility must enany significant med This REQUIREMENT by: Based on observative review, the facility free of significant in 1 of 4 residents (R1 Findings include: R145's Physician's indicated R145 had (Lantus Solostar 15 times daily for diable on 10/26/15, at 7:0 (RN)-H was observed open the cart obtained a Lantook the cap off obtained it to the cleansing the rubbe sides of the safe to the cleansing the rubbe sides of the safe to the safe to the cleansing the rubbe sides of the safe to the safe	a out, check for air bubbles by test two more times to the test two more times to the needle may be the needle and try again. The out after changing the tar® may be damaged. Do not DENTS FREE OF DERRORS that residents are free of ication errors. In the needle may be defended to the new test and document ailed to ensure residents were sulin administration errors for 145). Orders dated 10/29/14, I an order for Glargine insuling to units) subcutaneous two	F 3		out the ve Insulin orders III on extense Insulin next review	12/3/15

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10/	29/2015
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 333	of insulin to pre-fill and the radministering cleanse the right low then punched the amotion gave the insuling. At 7:12 p.m. when was for priming the "When I was traine priming. I will check on 10/27/15, at 8:30 nurse (LPN)-E was Solostar insulin for a pair of gloves operate rubber seal of the AutoShield on then insulin. As LPN-E wadminister insuling the cart went over to the heard ask RN-F who during the conversa and asked what suppense. -At 8:35 a.m. RN-F the nurses were just amount of insuling on -At 8:36 a.m. surverback to the cart and nurses were supported the different restricts and ordered manufacturer instrustated she would fill -At 8:48 a.m. the different restricts and the different	the needle. went to R145's room and oral medication was observed wer abdomen area let air dry trea and using constant firm sulin. asked what the facility policy insulin pens RN-H stated d here I was never told about	F 333	9.The Director of Nursing remain responsible to ensure residents of any significant medication errors.	are free	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
	245267 B. WING		10	/29/2015			
	NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 333	pen I would expect ordered amount." What priming was E what you mean." -At 8:58 p.m. DON known the Flexpen and provided manuflexPen which indissupposed to be present of the procedure all over a surveyor present. On 10/27/15, at 3:5 he did not administ answer to it. When expected 12 units the agreed and added be any harm if they on 10/29/15, at 3:3 consultant pharmac prime the pens acconstructions" when a nurses were support two units of insulin dialing the ordered. The package insert March 2007 from Sidirected staff to: "Step 3. Perform a Always perform the injection. Performing you get an accurate."	the nurses to dial up the When surveyor was explaining DON then stated "I now know stated all nurses should have was supposed to be primed afacturer instructions for the cated the device was e-filled with two units. was observed give LPN-E ter LPN-E completed the correctly with DON and asked if he would have to be delivered as ordered MD "if you're asking if there would got 10 or 14 units, no." 10 p.m. via phone the cist (CP) stated "They should ording to the manufacturer 's the CP was asked if the sed to prime the pens with to pre-fill the syringe prior to amount. 11 for Lantus Solostar dated anofi-Aventis U.S. LLC 12 Safety test each go the safety test ensures that the dose by: 13 and needle work properly	F 33	33			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10/29/2015		
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 333 F 371 SS=E	selector. B. Take off the outeremove the used not the inner needle car. C. Hold the pen with upwards. D. Tap the insulin rebubbles rise up town. E. Press the injection of insulin comes out you may have to petimes before insuling off insuling comes and repeat the safe remove them. If still no insuling comes needle, your Solos use this Solostar." 483.35(i) FOOD PRSTORE/PREPARE/ The facility must - (1) Procure food froconsidered satisfact authorities; and (2) Store, prepare, under sanitary conditions.	2 units by turning the dosage or needle cap and keep it to deedle after injection. Take off p and discard it. In the needle pointing deservoir so that any air reards the needle. In button all the way in. Check of the needle tip. Derform the safety test several is seen. It out, check for air bubbles that two more times to mes out, the needle may be the needle and try again. It out after changing the tar® may be damaged. Do not accurately expected or trory by Federal, State or local distribute and serve food	F 33			12/3/15	
	by: Based on observat	tion, interview and document		The link and kitchen have beer	ı		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245267	B. WING		10/2	10/29/2015	
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 371	procedures were for possibility of food by kitchen and hallway affect 140 of 141 restricted the kitchen. Findings include: During the kitchen of the following was oregistered dietitian. - the 'link' hallway by kitchen and assisted unkempt, littered wowith a buildup of a little the seam where the racks of buns and by the hallway right accept the hallway right accept to the outside employee smoking numerous boxes are kitchen equipment hallway, six uncoveresident use cups arolling carts with too cereal, three rolling the top shelf. Two completes the cover. RD states out after each mean what the boxes of each the hallway, open edirectly across from contained a plastic sprinkles dated 5/2	ailed to ensure food sanitation ollowed to minimize the orne illness in the main y. This had the potential to esidents who eat food out of tour on 10/26/15, at 11:44 a.m. bserved and confirmed by the	F 37	cleaned and unnecessary items of from the link and lockers. A profecteaning company was hired to decleaning of all surfaces in the kite. Staff will be re-trained on sanite conditions of the kitchen and link survey examples cited in the 256. Dining management has dever cleaning schedules to address all the kitchen and link sanitation procedures. This will be monitored Director of Dining Services. Facil leadership will audit the kitchen at 2X weekly until the next QA & A M 12/15/15. The Director of Dining Service review the completed audits and any identified concerns to the fact & A Committee for review and fur recommendations. The Executive Director remain responsible for compliance with the requirement to ensure that sanital conditions are met to minimize the possibility of food borne illness.	ssional o a deep hen. cary using 7. loped areas of ed by the ity nd link fleeting s will bring lity QA ther s nis ry		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245267	B. WING _		10/29/2015		
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP COD 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 371	was approximately undated one gallon approximately 1/3 for opened approxim	er of pancake/waffle syrup that 1/3 full dated 3/27, an container of molasses ull, a large can of pumpkin tely 1/4 of the can top with an "I don't know what they are will be thrown out." It do f the hallway directly inside the kitchen was an employee wo compartment sink verified or rinse off food and a six foot of the right of the sink. Behind re was a heavy buildup of ebris on and around all the and in the grout of the back area behind the two and handwash sink was wen food material. A baseboard in the handwash sink was med this area was dirty and tating "I know, I'm aware." For had a heavy buildup of a sith food particles and debris side of the freezer, under the ne entrance corners to the up of a brown/black P kitchen tour on 10/29/15, at wing was observed and inistrator (A), director of dining	F 37	1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245267 B. WING			10	/29/2015		
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 371	there was a brown Across from the stoparticles/debris little shelving. - Wall behind the the heavily splattered wand around all sink there was a brown/ The garbage disporgrime on the entire stated "yes I do see cleaning sheets that responsible to clear it should be done done do the company of the passed of the floors are mopposite the floors are mopposite was no deep making one soon." - Wall behind the ica a brown substance. - Wall and floor to the machine was splatt substance. Administ have a deep cleanit During an interview DD stated the food was food that was the state of the s	Il step stool on the left side sticky substance on the floor. Fool there was a buildup of food ared on the floor under the stree compartment sink was with a brown substance. On legs and back baseboard black buildup of food debris. Sal had a buildup of dust/dirt outside of the disposal. DD eti." DD stated there are daily at outline what staff is n, "I don't have sign off sheets, aily." perimeter of the kitchen along don and around all legs of as a heavy buildup of and food debris. DD stated bed two times a day and that cleaning policy but "I will be the machine was splattered with the right of the fruit juice ered with a black/brown sticky strator stated "we need to		71			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10/29/2015	
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 371 F 372 SS=D	DD stated all spills should be cleaned a expectation." Review of undated Cleaning List week out coolers and swe 2) pull out all cookin mop floors (Tuesda cooler and frezzer [delime dishwasher mop storage room 483.35(i)(3) DISPO PROPERLY	on 10/29/15, at 12:26 p.m. in the refrigerators or freezers as you go, "It's an facility Miscellaneous Kitchen y cleaning indicated "1) pull eep and mop floors (Monday), ag equipment and sweep and y), 3) sweep and mop out sic] floors (wedesday) [sic], 4) (Thursday), 5) sweep and	F 37		12/3/15	
	by: Based on observat review, the facility for containment of gark to prevent attracting area observed. Findings include: During the initial kit 11:44 a.m. with the brown dead rat was outside dumpster. Fright away." To the were two plastic ba	ion, interview and document ailed to ensure proper page in the outside dumpsters pests for 1 of 1 trash storage chen tour on 10/26/15, at registered dietitian (RD), a sobserved behind the large RD stated "I will tell someone right of the dumpster there gs of trash laying on the cycling container that was not		 Rodent and trash bags were refrom the ground near the dumpster all leaves were cleared from the are Staff have been in-serviced on the trash removal procedures and import of placing items directly into the dumpster. Environmental staff will complete audits 2X weekly until the next QAS meeting 12/15/15. Housekeeping Director will revise completed audits and bring any ide concerns to the facility QA&A Common for review and further recommendats. The Executive Director remains 	es, and ea. the cortance e &A ew entified mittee ations.	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245267	B. WING		10/	/29/2015
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	away from the dumonly four feet from the employees took our an employee smokknow where that cattrash bags should had dumpster and not company country and the worked at the far not been any pests control company received and the far not been any pests control company received at the far not been any pests control company received at the far not been any pests from 12/16/14 thru no pest activity insignation of the facility must produge and biological them under an agres §483.75(h) of this punlicensed personn law permits, but on supervision of a lice.	was approximately 10 feet pster and dead rat, however the door entrance where the trash and had access to ing area. RD stated "I don't ame from" and verified the nave been in the outside on the ground. on 10/28/15, at 9:03 a.m. the or (MD) stated an outside pest omes onsite every month and e was aware of in the 11 years cility. MD stated there have inside the facility per the pest ports. Service Inspection Reports 9/23/15, indicated there was de the facility with 3 of 11 house mouse was located impster area. Inment policy was provided. RMACEUTICAL SVC - EDURES, RPH ovide routine and emergency als to its residents, or obtain ement described in part. The facility may permit need to administer drugs if State lay under the general ensed nurse.	F 37	responsible for compliance with requirement to ensure that we do attract pests in our trash storage	o not	12/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245267	B. WING		10/29/2015	
	PROVIDER OR SUPPLIER	ER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 425	the needs of each r The facility must en a licensed pharmac on all aspects of the services in the facil	drugs and biologicals) to meet resident. Inploy or obtain the services of cist who provides consultation be provision of pharmacy	F 425			
	by: Based on observatoreview, the facility of ensure Fentanyl particles destroyed to prevent residents (R145, R15). Findings include: 1 East Unit On 10/27/15, at 2:1 medication cart was nurse (RN)-G who medication cart and narcotic box to the opened box of Fentasked what the facility destroying used particles and located in the medication cart and narcotic box to the opened box of Fentasked what the facility destroying used particles and located in the medicated in the medicat	tion, interview, and document did not have a system to tches were accurately nt potential diversion for 2 of 2 124).		1.Fentanyl destruction records were initiated at the time of survey for ideresidents R124 and R145. 2.Other residents with an order for Fentanyl patches have had a destruction record initiated. 3.PharMerica Nurse Consultant will conduct a Medication Administration service for Licensed Nurses on 11/4.Nursing Leadership will conduct narcotic/fentanyl patch audits week the next QA&A meeting 12/15/15. 5.The facility QA&A committee will completed audit results and make for recommendations. 6.The Director of Nursing remains responsible for compliance with this requirement to ensure that pharmaceutical services are provided meet the needs of each resident.	entified uction I n in 19/15. dly until review further	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
	245267 B. WING		10/29/2015				
	NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 425	was completed with (LPN)-E who provide narcotic box. Inside front were two boxed R124 and R145 with respectively. When was revealed there throughout. When a was for destroying stated another nursed destroying the patch nurses documented When asked if a provide provide provide the provide the patch of th	15 p.m. a medication cart tour a licensed practical nurse ded access to the cart and the expectation that the medication cart to the expectation of the patches left reviewing the narcotic book it was only one nurse signature asked what the facility policy the used patches, LPN-Expectation with the medication and the patches when the however neither of the difference of	F 42	5			
	indicated R145 had patch 72 hours 50 mused for pain). R145's diagnoses i amputation, chronic obtained from quark (MDS) dated 9/18/12 During review of R2 Administration Recent through 10/29/15, it Fentanyl patch remaines with only one be determined if the one nurse signed of the state of t	c pain, neuropathy and gout terly Minimum Data Set					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		245267	B. WING _		10/	29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 425	indicated R124 had patch 72 hours 25 in R124's diagnoses in left hip, age related rheumatica and his obtained from face. During review of R2 Administration Recent through 10/29/15, in Fentanyl patch remained if the one nurse signed of patch no destruction On 10/29/15, at 2:5 (DON) stated she waware of the form the destroying Fentanyl facility had a form from the destruction of the destruction of the form from the pharm expectation was of Fentanyl patches to	Orders dated 10/29/15, I an order for the Fentanyl mcg/hour. Included chronic pain, pain in osteoporosis, polymyalgia tory of traumatic fracture sheet dated 10/29/15. I24's Electronic Medication ord (EMAR) dated 10/1/15, twas revealed R124 had the loved and disposed of ten nurse signing off. It could not be were two nurses as only ff for applying of the Fentanyl n/removal documentation. I p.m. the director of nursing was not aware nurses were not hey needed to complete when I patches. DON stated the or destruction. I p.m. on a telephone onsultant pharmacist stated, a documenting two nurses for the patches. I know there is a macy" when asked what his the facility with destruction of	F 42	,		
	not address Fentar procedures for nurs not indicate who wa nurses were consis	ayl destruction and facility ses. In addition, the policy did as responsible to oversee, if stently documenting Fentanyl revent potential diversion. In				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY IPLETED
		245267	B. WING _		10/	29/2015
	PROVIDER OR SUPPLIER HONY HEALTH CENTE	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	addition the policy at the disposition of Fidiversion. Controlled Medication 12/12, directed "Medication 12/12, di	and procedure did not address entanyl patches to prevent ion Storage policy dated edications included in the Drug histration (DEA) classification ance are subject to special disposal and record keeping in the interin accordance with other applicable laws and olicy did not indicate who was uring the Fentanyl patches en destroyed to prevent DRUG RECORDS, UGS & BIOLOGICALS inploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an antion; and determines that drug in and that an account of all maintained and periodically als used in the facility must be not with currently accepted oles, and include the ory and cautionary e expiration date when in the sunder proper temperature to only authorized personnel to	F 42			12/3/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		SURVEY PLETED
		245267	B. WING		10/2	29/2015
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	permanently affixed controlled drugs list Comprehensive Druction Control Act of 1976 abuse, except when package drug distriquantity stored is many can be readily determined to the control of the contro	ovide separately locked, discompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the hinimal and a missing dose cted. NT is not met as evidenced tion, interview and document discompanies to ensure that 2 of 2 in the subacute unit were e potential to affect 19 of 27	F 43 ⁻	1. The Medication Administration a Storage policy has been reviewed. 2. PharMerica Nurse Consultant wil conduct a medication administration in-service on 11/19/15. 3. Staff will be in-serviced on medicadministration using specific surversexamples. 4. Nursing Leadership will conduct medication cart audits 2x/week un next QA&A meeting 12/15/15. 5. The facility QA&A committee will completed audit results and make recommendations. 6. The Director of Nursing remains responsible for compliance with this requirement to ensure that pharmaceutical services are provided meet the needs of each resident.	I n ation y til the review further	
	medication cart9:08 a.m. a female	resident passed the unlocked				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245267	B. WING _		10	/29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COD 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	visible in hallway9:09 a.m. RN-D re and locked it. During random con 10/28/15, at 9:16 at two was left unlock office9:18 a.m. RN-D locart two. During interview on verified that medica unlocked. RN-D state contained blood premedication for treat sugars), coumadin creams. During interview on subacute nurse macart should be lock. The nurse should a RN-C stated it wou	turned to medication cart one tinuous observation on m. sub acute medication cart ed when RN-E went into an oked sub acute medication cart ed when RN-E went into an oked sub acute medication at 10/28/15, at 9:09 a.m. RN-D ation cart one was left ated the medication carts ressure medications, insulin (a rement of elevated blood (a blood thinner) and various at 10/28/15, at 9:35 a.m. RN-C reager stated a medication red if out of the nurses reach. It least be able to see the cart. It least be of the cart at the sitting at the	F 43	,		
	stated, "I don't usua	10/28/15, at 9:40 a.m. RN-E ally leave my medication cart to catch the doctor to update at's condition."				
	director of nursing s medication cart is of should be locked. It	10/29/15, at 2:32 p.m. she stated, "When a out of the nurses line of sight, it f the nurses are at a desk rtif it is in their line of sight, it				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245267	B. WING		10/	29/2015	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 431	indicated"Medica medication supplies not in use or attend access."	on Policy dated 09/10, tion rooms, cabinets and s should remain locked when ed by persons with authorized	F 4			40/0/45	
F 441 SS=D	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the transmission of dise (a) Infection Control The facility must es Program under whith (1) Investigates, coin the facility; (2) Decides what proshould be applied to (3) Maintains a reconstruction are represented to in (b) Preventing Spreadisolate the resident (2) The facility must communicable dise from direct contact will tread (3) The facility must (3) The facility must contact will tread (4) The facility must contact will t	ease and infection. I Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections. and of Infection ion Control Program esident needs isolation to of infection, the facility must a prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which	F 4	41		12/3/15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245267	B. WING		10/2	29/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	transport linens so infection.	-	F 44 ⁻			
	review, the facility finfection control me residents (R43) rev facility failed to disinattaching the needl during insulin admir practice also had thother residents who Findings include: Proper hand washin R43's was observe The bedroom door and lights were out her backAt 7:11 a.m. R43 whow she had slept she was stiff and di or bad thing. R43 ir left hand and shoul medication and to g-At 7:14 a.m. surve practical nurse (LP) request to get up.	tion, interview and document ailed to ensure appropriate easures was used for 1 of 3 iewed for morning cares. The offect an insulin pen prior to e for 1 of 4 residents (R145) instration. This deficient are potential to affect three of utilized insulin pens. In the potential to affect three of utilized in		1.The facility Infection Control poliprocedures has been reviewed 2.Staff will be in-serviced on Infection Control (hand washing) and Insuling pens using specific survey example 3.The nursing leadership will compound NAR care audits and Insuling flex pension administration audits 2x/week until next QA&A meeting on 12/15/15. 4.The Director of Nursing will revied completed audits and bring any idea concerns to the facility QA&A comfor further recommendations. 5.The Director of Nursing remains responsible for compliance with this requirement to ensure a safe, sanitiand comfortable environment to prothe development and transmission disease and infection.	on iflex es. lete en the wentified mittee s tary, event	

-			TE SURVEY MPLETED			
		245267	B. WING _		10	/29/2015
	PROVIDER OR SUPPLIER HONY HEALTH CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CO 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	assistant (NA)-D w bedside then went towel came back a wash her faceAt 7:35 a.m. NA-E R43 was in her gro ready for the day. N was going to get he-At 7:36 a.m. to 7:3 assist R43 with car body including the pants half way as trace and the completed pen NA's cued R43 to reduce the completed pen NA's cued R43 to reduce the completed pen NA's cued R43 to reduce the soiled hands, NA-D went across from R43's box was empty, the side scrubs pocket applied it. NA-D the going outside the rewheelchair. Still not the room went outs wheelchair into the observed adjust R4R43 they were goin at the edge of bed wheelchair. At 7:42 apply R43's shirt as At 7:44 a.m. with ben NA-D applied a trait then cued R43 to significant to the country of the co	entering R43's room nursing as observed standing at R43's to the bathroom got a wash and cued R43 she was going to came into the room indicated up and was going to get her NA-D indicated to R43 NA-E er ready. 9 a.m. both NAs continued to es and cleaned her upper back and applied socks and	F 44			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245267	B. WING _		10	/29/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	applied eye glasse -At 7:49 a.m. after observed enter roc intervened and wh NA-D acknowledge hands after providi observed stated "I as NA-D entered ro On 10/28/15, at 1:' (RN)-F stated it wa wash hands before gloves. RN-F furthe to have removed g they had provided involved the staff whands with soap an with cares. On 10/29/15, at 9:0 manager stated wh "Staff are suppose and after removing cares, before leavi Hand Hygiene poli "1. Hand hygiene r a. Whenever h or soiled. b. Before and a c. After contan environmental surf resident. d. Before assis handling food.	in to comb R43's hair and is never washed hands still. Ileaving R43's room NA-D was om 241 and that time surveyor en asked about hand washing. It is a she had not washed her ing pericare with stool will wash my hands right now om 241. If p.m. registered nurse is the facility policy for staff to exapplying and after removing er stated staff was supposed alloves and washed hands if pericare and with stool being was supposed to wash their and water before proceeding. If a.m. LPN-D unit nurse is nen asked about hand washing do to wash their hands before in their gloves, before providing ing the room." If y dated 10/8/15, directed: requirements: ands are visibly contaminated after contact with residents. It with contaminated acces adjacent to the sting residents with eating or in the sting residents with eating the sting	F 4	41		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING			10/:	29/2015
	PROVIDER OR SUPPLIER	ER .		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	f. Before and a g. After coughin nose and or assisticoughing, sneezing h. After handlin such as raw meat of i. Before perfor procedure and after worn" Disinfect an insulin needle On 10/26/15, at 7:0 set up R145's bedtiset up RN-H R145 draw of the medical Solostar Flexpen for obtained an AutoStothe top of the Flex Frubber seal with alconsulin. At 7:11 p.m. RN-H after administering cleanse the right lothen punched the amotion gave the insulin applying the AutoSclean the rubber seal. On 10/29/15, at 2:5 (DON) stated the next and the results of the next and the rubber seal.	den, towels, wash cloths. Ifter smoking or eating. Ing, sneezing, or blowing of Ing residents after Ig and blowing of nose. Ing uncooked animal products, Ing ing a resident care ADL In removal of gloves if In pen prior to attaching the In pen pr	F	141			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245267	B. WING		ļ	10/2	29/2015
	PROVIDER OR SUPPLIER	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 441	follow hand washin 2/15, Lantus SoloS	tated staff were supposed to g policy when providing cares. tar Instruction Leaflet directed Rubber Seal with alcohol"	F 4	41			

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245267

B. WING

10/29/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST

ST ANTH	IONY HEALTH CENTER		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	
K 000	INITIAL COMMENTS	K 00	0		
	FIRE SAFETY			2	
	THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.				
21	UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.				
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St. Anthony Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.			6	
	PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:		EPOC		
	HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145				
	Or by email to:				
ABORATOR	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

Electronically Signed

11/27/2015

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

Facility ID: 00522

program participation.

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				X3) DATE SURVEY COMPLETED	
		245267	B. WING			10/2	9/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	Marian.Whitney@sor Angela.Kappenma THE PLAN OF CODEFICIENCY MUS	ofate.mn.us on@state.mn.us orrection for EACH orr	K	000				
	3. The name and/oresponsible for co	roposed, completion date. or title of the person rection and monitoring to the deficiency.						
	with no basement at 2 different times constructed in 196 Type II(111) const was constructed to determined to be Because the originare of the same ty existing buildings, one building. The building is ful has a fire alarm so corridors and sparmonitored for autonotification.	The building was constructed as. The original building was 37 and was determined to be of ruction. In 1997, an addition to the East Wing that was of Type II(111) construction. In all building and the 1 addition the facility was surveyed as by fire sprinklered. The facility yetem with smoke detection in the corridors that is smatic fire department						
	The facility has a	capacity of 150 beds and had a						

(X2) MULTIPLE CONSTRUCTION

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

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY
		245267	B. WING			10/2	9/2015
	PROVIDER OR SUPPLIER			37	REET ADDRESS, CITY, STATE, ZIP CODE 100 FOSS ROAD NORTHEAST T ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 046 SS=D	A K-067 has been further detailed invention that The supply and meets the CMS S8 2006. The requirement at NOT MET as evide NFPA 101 LIFE SA Emergency lighting provided in accord This STANDARD Based on observations staff, the facility has emergency lighting accordance with N and 19.2.9.1. This residents, staff and emergency evacuations include: On facility tour bett 10/29/2015, during emergency battery maintenance documents of the Maintenance of the facility could not verifying that 2 of the supplements of the Maintenance of the facility could not verifying that 2 of the supplements of the Maintenance of the facility could not verifying that 2 of the supplements of th	written in past surveys. upon estigation it has been found direturn for the 1967 building C-06-18, letter from May 26, the 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD To of at least 1½ hour duration is		0000	 The facility will keep monthly reindicating that the emergency batter backup lighting has been tested. December 3, 2015 The Director of Maintenance wireview completed records monthly ensure compliance. Maintenance will bring any concerns to be review monthly at the QA&A Meeting. 	ecords ery ill to Director	12/3/15

Facility ID: 00522

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

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

1 "	9	IPLETED
245267 B. WING	10/	29/2015
NAME OF PROVIDER OR SUPPLIER STANTHONY HEALTH CENTER STANTHONY, MN 55421	PCODE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CONTROL OF CO	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 046 Continued From page 3 K 046		
This deficient practices was confirmed by the Maintenance Director (BS).		
		- Hi



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted November 20, 2015

Ms. Mary Yaeger, Administrator St Anthony Health Center 3700 Foss Road Northeast St Anthony, MN 55421

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5267027

Dear Ms. Yaeger:

The above facility was surveyed on October 26, 2015 through October 29, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency 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 attached Minnesota Department of Health orders being submitted 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

St Anthony Health Center November 20, 2015 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule 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 me.

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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health STATEMENT OF DEFICIENCIES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00522	B. WING		10/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	IONY HEALTH CENT	-R	SS ROAD NO ONY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall with a schedule of the Minnesota Dep					
	requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tag alle number indicated below. In several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will sment of a fine even if the item aring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/27/15 **Electronically Signed**

TITLE

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00522	B. WING			9/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	surveyors of this De above provider and orders are issued. electronic plan of co	27th, 28th and 29th 2015, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted.				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for				
	column entitled "ID statute/rule out of co "Summary Stateme and replaces the "T correction order. The findings which are in after the statement evidence by." Follow	umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column o Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and crection.				
	FOURTH COLUMN "PROVIDER'S PLA	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

Minnesota Department of Health

STATE FORM 6899 MVY611 If continuation sheet 2 of 60

Minnesota Department of Health

			(X3) DATE COMP	SURVEY LETED		
		00522	B. WING		10/2) 29/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ST ANTH	IONY HEALTH CENTE	R	S ROAD NO DNY, MN 55	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/3/15
		omprehensive plan of care personnel involved in the .				
	by: Based on observati review, facility failed resident in accorda	ent is not met as evidenced on, interview, and document d to check and change a nce with their plan of care, for ents observed for activities of		Corrected		
	Findings include:					
	R289 had an alteration and instruction and instruction upon rising, before	ort dated 10/28/15, instructed tion in bowel and bladder ted staff to toilet the resident and after meals, with night ded. R289 was to be checked urs.				
	sheet indicated R28 Resident Care Sum	ant (NA) undated assignment 89 incontinent of bladder. Imary POC undated instructed ange Q 2hr" copy requested				

Minnesota Department of Health

STATE FORM 6899 MVY611 If continuation sheet 3 of 60

iviinnesc	<u>ita Department of He</u>	aith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00522	B. WING			9/2015
NAME OF 1		070557.40	DDEGG OFFICE	STATE ZID CODE		0,00
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO			
			ONY, MN 55			T.
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
2 565	Continued From pa	go 3	2 565			
2 303	Continued i Tom pa	ge 5	2 303			
		ation on 10/28/15, from 7:06				
		n. noted the following:				
		t was sleeping in room.				
		assistant (NA)-A explained to				
		e going to help R289 get up				
		A-A opened incontinent brief				
	and attempted to w					
		d NA-C told R289 that they				
		that R289 did not want to get				
		R289 to use call light to call				
		n ready to get up and left				
		bed covered with a sheet.				
		n red anti slip socks and black				
		rtially pulled up legs.				
		s open under R289's buttocks. ed nurse (RN)-D spoke with				
		to get up for breakfast.				
		d NA-B informed R289 that				
		et R289 up for breakfast				
		nd NA-B put a dry incontinence				
	product on R289.	ia iii i b pat a ary moonamoneo				
		way to dining room.				
		brought to sitting area next to				
	nursing station.	or original to criming an our mount to				
		es-A took resident to church.				
	-10:42 a.m. Reside	nt at church at Chandler				
	Place.					
	-10:47 a.m. Church	service started.				
	-11:34 a.m. Activitie	es staff-A informed surveyor				
		unit. R289 did not stop any				
		. R289 did not go to the				
		church. R289 was seated next				
	to desk.					
		aken to room and incontinent				
	pad checked. R289	was dry.				
	Desiran interests	10/00/15 -110 15				
		10/28/15, at 10:45 a.m.				
	Activities staff-A sta	ated, "I let the staff know				

Minnesota Department of Health STATE FORM

6899 If continuation sheet 4 of 60 MVY611

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY LETED
			A. BUILDING:			,
		00522	B. WING		10/2	9/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	IONY HEALTH CENT	-R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 4	2 565			
	During interview on stated, "After [R289 and now she is back	10/28/15, at 11:41 a.m. NA-A ate [R289] went to therapy k, we are to toilet R298 after by toileted R289 yet."				
	RN-C stated I would toileting, check and would expect the st RN-C verified the c	10/28/15, at 12:25 p.m. d expect them to attempt change every 2 hours. I raff to follow the plan of care. orrect toileting plan was to R289 every two hours.				
	director of nurses (10/29/15, at 2:35 p.m. DON) verified expected staff to nange every two hours if on				
	The director of nurs follow care plans in	THOD OF CORRECTION: sing could in-service all staff to regards to specific resident . Also to monitor for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			12/3/15
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen	A comprehensive plan of wed and revised by an methat includes the attending red nurse with responsibility dother appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal a representative at least a seven days of the revision of				

Minnesota Department of Health

STATE FORM 6899 MVY611 If continuation sheet 5 of 60

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING: COM		(X3) DATE COMP	SURVEY LETED
		00522	B. WING		10/2) 9/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	10/2	0/2010
		3700 FOS	S ROAD NO			
ST ANTH	ONY HEALTH CENTE	ST ANTHO	ONY, MN 55	421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 5	2 570			
	the comprehensive by part 4658.0400,	resident assessment required subpart 3, item B.				
	by: Based on observati review the facility fa was revised for 1 of included keeping th	ent is not met as evidenced on, interview and document illed to ensure the plan of care if 1 resident (R77) which e head of bed elevated to during continuous tube		Corrected		
	Findings include:					
	be in bed, with the I	8 a.m. R77 was observed to HOB raised only about 10 te feeding was being infused ().				
	observed to be lying elevated more than	30 a.m., R77 was again g in bed without the HOB 10 degrees. A tube feeding running at 70 ml's per hour				
	in bed. R77 was lyir in the bed. R77's he foot partially off bed were edematous. T degrees of elevation running at 70 ml's/h-At 9:30 a.m. staff v R77, when staff ent nurse (RN)-G immestated when asked	5 a.m. R77 appeared asleeping on back, but was crooked ead was toward wall and left I and the lower extremities the HOB approximately 10 in, with the TF attached and ir. I were prompted to observe ered the room, registered ediately elevated the HOB, and "the HOB should be elevated ing was running, should be at				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00522	B. WING		10/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST ANTI	ST ANTHONY HEALTH CENTER 3700 FC			RTHEAST		
OI AIIII	IONT HEAEITI GENTE	ST ANTHO	DNY, MN 55	421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 6	2 570			
	medication adminis nurse (LPN)-A, the degrees upon enter entire time LPN-A v LPN-A never elevat procedure, R77 approcedure, R77 approcedure, R77's admission rehad been admitted diagnoses of dysph phase, fracture of oweakness, use of g feeding (TF) directly inserted through the	7:01 to 7:04 a.m., during stration with licensed practical HOB was observed at 20 ring the room and during the was administering medication. Led the HOB during the beared to be asleep with eyes intire procedure. cord indicated the resident to the facility on 3/17/14, with lagia of the oropharyngeal rervical vertebra, generalized lastric tube (GT) (gastric tube by to the stomach by a tube to skin), pulmonary embolus glungs/lung function) and				
	indicated: Problem areas: "Nu aspiration risk, etc.) feeding, and Need seizures and dysph enteral feeding thro included: "Resident date of 1/27/16)" I "Resident monitore fluids; Appropriate r Adjustments will be resident to decreas MD [medical doctor orders (thick liquids observed by staff at fluids; NPO [nothing 5/17/15; oral care efeeding- continue to labs per facility protests."	atrition Need, (eating, as evidenced by tube for artificial nutrition related to agia as evidenced by need for augh 'GT' tube." Goals to tolerate tube feeding (goal interventions included: d at meals and when taking referrals will be made; and obtain appropriate to the ethe risk of aspiration; Notify and obtain appropriate to the ethe risk of aspiration; Notify and obtain appropriate to the ethe risk of aspiration; Notify and obtain appropriate to the ethe risk of aspiration; Notify and obtain appropriate to the ethe risk of aspiration; Notify and obtain appropriate to the etherisk of aspiration; Notify and obtain appropriate to the etherisk of aspiration; Notify and obtain appropriate to the etherisk of aspiration; Notify and obtain appropriate to the etherisk of aspiration; Notify and obtain appropriate to the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etherisk of aspiration; Notify and obtain appropriate to be the etheri				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00522	B. WING		10/2	29/2015
-	PROVIDER OR SUPPLIER	3700 FOS	DRESS, CITY, S SS ROAD NOI ONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 570	swallow clarification via cup sip if sitting small sips and chin (water) as ordered. identified the tube finterventions to dire of the bed during the high the HOB shou aspiration, nor was care plan that the resuch as having the On 10/29/15 at 9:46 lying in bed uncove TF was running at LPN-A was brought and verified the HOLPN-A elevated the listened the resider were clear." - At 11:11 a.m. RN-always be between risk of aspiration. - At 2:17 pm the direct the HOB should be 45 degrees, the DO be to have the HOB degrees to prevent The facility policy for 7/23/13, directed st 4. "Resident's with must have their HOB times." The American Soci Nutrition, Special Records 2009, indicated, "In research-based evi	n- Ok for nectar thick liquids upright and supervised. Use tuck; Provide TF and H20 "Although the care plan eeding use, there were no ect staff related to the position e GT feeding such as, how ld be to prevent potential there any indication on the esident refused any treatment HOB elevated, due to comfort. As a.m. R77 was dressed and red, the HOB was flat and the many indication on the esident refused any treatment HOB elevated, due to comfort. As a.m. R77 was dressed and red, the HOB was flat and the minto the room to observe R77, as should not be flat, and HOB to 30 degrees. LPN-A at lungs and stated the "lungs" B stated the HOB should 45 to 90 degrees to prevent ector of nursing (DON) stated elevated as much as tolerated on verified best practice would a elevated at a minimum 30 aspiration.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		00522	B. WING		10/2) 9/2015
	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S S ROAD NO DNY, MN 55		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	director of nursing of responsible for according resident cares and warranted. Also to resident PERIOD FOR (21) days.	HOD OF CORRECTION: The could in-service staff uracy of care plans to add services when a change is nonitor for compliance. R CORRECTION: Twenty One	2 570			
2 910	Incontinence Subp. 5. Incontiner have a continuous properties a continuous properties and a continuous properties and a comprehensive results and a resident without an indwellinunless the resident that catheterization B. a resident where the continuous properties appropriate prevent urinary traces.	ince. A nursing home must brogram of bowel and bladder uce incontinence and the catheters. Based on the dent assessment, a nursing that: no enters a nursing home g catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to it infections and to restore as er function as possible.	2 910			12/3/15
	by: Based on observati review, the facility fa reassess and provid services for 1 of 2 p	ent is not met as evidenced on, interview and document ailed to comprehensively de appropriate care and eatients (R24) reviewed who oley catheter (a thin, sterile		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00522	B. WING		10/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENT	-R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 9	2 910			
		ne bladder to drain urine which for a period of time).				
	Findings include:					
	was observed to had drainage bag contatime, R24 stated he place for six month had to go to the hose R24's current care indicated R24 had in urinary elimination evidenced by Foley antibiotic medication [urinary tract infections]	on 10/28/15, at 3:43 p.m. R24 ave a Foley catheter tube and ining clear yellow urine. At that e'd had the Foley catheter in sor better and had recently spital to have it changed. plan printed on 10/28/15, problems including: "alteration on related to diabetic as a catheter in use and history of a for a diagnosis of UTI on]" and "Indwelling catheter nary retention with obstruction failure.				
	indicated R24 had lindwelling Foley car indicated staff had catheter, but R24 h Foley removed tom Clinical Notes indic place until 9/29/15, attempted (unsucce	sion Clinical Note dated 5/5/15, been readmitted with an theter. A note from 5/8/15, been going to remove the ad "requested to have the orrow morning (5/9/15)." The ated the catheter remained in when a nurse removed and essfully) to reinsert it.				
	was ordered to hav during morning shif "Writer tried two tim 16 F [French, a uni was unsuccessful. ordered a Coude' ti that maneuvers arc	dated 9/29/15, indicated R24 e indwelling catheter changed it due to risk for infection. nes to insert new Foley using a t of measurement] catheter but NP [nurse practitioner] then p Foley catheter" [a bent tip bund obstructions leading to was the type of catheter that				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00522	B. WING			29/ 2015
	PROVIDER OR SUPPLIER	3700 FOS	DRESS, CITY, S S ROAD NOI ONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	"Writer, with the ass manager tried the promplete task. NP ER [emergency roo unsuccessful. [R24 but declined at this been voiding now'. output throughout sintervene as appropriately ap	inserted in the hospital in May. sistance of another floor nurse procedure, yet unable to gave order to send resident to m] for further evaluation if I informed with above order time. Resident stated 'I have Nursing monitoring [R24's] hift for possible retention and	2 910			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					С		
		00522	b. Wind		10/2	9/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO				
	OLIMA AA DV OTA		ONY, MN 55			0.470	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 910	Continued From pa	ge 11	2 910				
	update regarding of from yesterday. [R2 whatever she said I put catheter in right updated on output a okay to send to ER request." The notes hospital 10/1/15, at insertion.	this time, writer to call NP to utput and bladder scan result [24] saying 'I don't care I need to and I want to go to a now, you hear me', NP and bladder scan yesterday, to put catheter in per [R24] is indicated R24 was sent to the 10:15 a.m. for catheter					
	R24 had been sent indwelling catheter culture completed v	to the hospital 10/1/15 for an replacement and had urine which was positive for a UTI, een initiated for R24.					
	indicated the reside facility: "Foley intac was started on Cipr days for UTI." The returned with orders including; to be see catheter replaceme	y dated 10/2/15, at 3:55 p.m. ent had arrived back at the t, output 800 cc, urine yellow, to 500 milligrams [mg] x 7 notes also indicated R24 had as related to the Foley en by urology monthly for ent, and for nursing to continue /symptoms of infection and s needs.					
	any indication that the changed from 5/5/1 physician and nurse 5/7/15 through 10/1 notes did not addrest to his hospitalization infection. In additional prior to 10/2/15, lact provide care and tracatheter such as; s	24's medical record lacked the catheter had been 5 to 9/29/15. In addition, e practitioner notes from /15, were reviewed. Their ss the indwelling catheter prior of for catheter replacement and on, the Physician Order Sheets ked any direction for staff to eatment of the indwelling ize of catheter, balloon size, approves to monitor for, and					

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED	
						;	
		00522	B. WING			9/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY (STATE, ZIP CODE	•		
TW WILL OF T	THO VIDE IT OIT OOF I EIE IT		S ROAD NO	,			
ST ANTH	IONY HEALTH CENTE	-R	ONY, MN 55				
	OLIMAN AND VOTA					0.5-1	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE	
				DEFICIENCY)			
2 910	Continued From pa	ge 12	2 910				
	when to replace the	indwelling catheter.					
	When to replace the	mawening dameter.					
		Bowel and Bladder Evaluation					
		cated R24 was continent of					
		catheter placed. This					
		R24 was at risk for					
		being immobile, and was					
		d - made poor decisions, and on two staff for transfers. The					
		ddress diagnoses which could					
		nence, i.e, kidney calculi and					
		eart failure) which had been					
		of admission per the 5/15					
	hospital discharge	documents. The evaluation					
		a review of medications that					
		dysfunction such as: use of a					
		ntidepressant use (Effexor),					
		droxyzine), and use of narcotic					
		xycontin and oxycodone PRN					
		of these medications were y 2015 Physician Order Sheet.					
		d Bladder Evaluation indicated					
		ary retraining had been done					
	with no improvement						
		he Evaluation, nor in the					
	Clinical notes to ind	licate when such retraining					
		d prior to the removal of the					
		n the Evaluation form there					
		ified as: Evaluation For					
		welling Catheters. This					
		dications for a Foley such as:					
		exact measurement of urine					
		such as unstageable pressure					
		ess, severe impairment and actable pain, or untreatable					
		ausing urinary retention					
		/R of over 200 milliliters (ml)					
		perform intermittent					
		ee failed attempts). This					
		el and Bladder Evaluation form					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILANC	OF CONTECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
		00522	B. WING		10/2) 9/2015	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST ANTHO	ONY HEALTH CENTE	-R	S ROAD NO				
		ST ANTHO	ONY, MN 55	421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 910	Continued From pa	ge 13	2 910				
	indicated residents should meet at least conditions, however Finally, the Evaluating removal plan, or risting from the use of a cablockage, bypassing bleeding or expulsion A quarterly Minimur 7/10/15, indicated Final diabetes, renal insubladder with an individual management of the form was completed a completed from was completed a catheter change during for transfers. In R24 was at risk for immobile, and was poor decisions, and staff for transfers. In R24 had antianxiety lorazepam), and a resultation order Short order Sheet post 10 R24 seen by the uncatheter change during Evaluation form ren R24 diagnoses and plan or risks/complied a catheter such a seen such a catheter at least a catheter and catheter such a catheter such	with indwelling catheters at one of the identified r R24 did not meet any. on form failed to indicate any ks of complications resulting atheter such as infection, gurine, pain, discomfort, on. In Data Set (MDS) dated R24 had diagnoses of afficiency and neurogenic welling Foley catheter. The was cognitively intact. Bowel and Bladder Evaluation d at 11:16 a.m The dicated R24 was continent of catheter placed. The lathe same outcome as the ed 5/5/15, with this exception: incontinence due to being cognitively impaired - made lawas dependent upon two in addition, the form indicated	2910				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00522 B. WING			C 10/29/2015		
		00522			10/2	9/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST ANTI	HONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE	
2 910	On 10/29/15, at 9:0 (RN)-F was intervied catheter had been further verified the reinsert a catheter soutput, and had upon R24 had been sent replacement on 10/25 further verified the facility, he had reacheter replacement there had not previous there had not previous there had not previous there had not previous there change into the catheter change into the catheter change into the facility had door catheter in or change have gotten some to kept the Foley in. The aware R24 had gorn have his catheter of catheter had been procedure. The DC catheter, and would the catheter change on 10/29/15, at 3:1 protocol was most monthly, per specific explained it was exadmitted with a Foliobtain orders to discontinuation medically necessarial medically	3 a.m. registered nurse wed. RN-F confirmed R24's removed on 9/29/15. RN-F nurse had not been able to so they'd initiated monitoring dated the MD. RN-F stated to the hospital for Foley (1/15, and had been admitted. that when R24 came back to new orders for monthly ent by urology. RN-F stated ously been orders for monthly cluding size or type of catheter. 4 p.m. the director of nursing was aware R24 had a catheter, ed to let staff take it out. The had routinely updated the NP, DON), was unaware whether umented orders to keep the ge it, and verified they should ype of orders since R24 had he DON also stated she was ne to the hospital on 10/1/15 to hanged. She stated his reinserted in a surgical N also said R24 wanted the d now go in every month to get	2 910				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
			A. BOILDING.		С		
		00522	B. WING			9/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST ANTH	IONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 910	Continued From pa	ge 15	2 910				
	in her role as a nurs 2015.	se manager since September					
	dated 7/31/12, indicindwelling catheter be assessed for ap catheter information along with the reast residents with cathet monitoring and doc progress notes, and would be changed a days based on their Although the policy catheter, R24 lacket indwelling catheter	coolicy for indwelling catheter cated the resident with an for more than 14 days would propriate indications, that the n would be on the plan of care on for the catheter, all eters would have ongoing umentation in the nurse's dithat a resident's catheter more or less than every 30 r assessment. directed to assess the ed a re-assessment of the and did not have an low often the catheter should					
	The director of nurs review and revise p to indwelling Foley develop an audit to provision of cathete could provide staff	THOD OF CORRECTION: sing (DON), or designee, could olicies and procedures related catheters. The DON could ol and could monitor the er care. In addition, the DON education related to following licies for appropriate care of have catheters.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 930	MN Rule 4658.0525 Nasogastric, Gastro	5 Subp. 7 B. Rehab - ostomy tubes	2 930			12/3/15	
	Subp. 7. Nasogast and feeding	ric tubes, gastrostomy tubes,					

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STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
			A. BUILDING:	·	С		
		00522	B. WING			, 9/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
ST ANTI	ONY HEALTH CENTE	- 🗠	S ROAD NO DNY, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 930	syringes. Based of assessment, a nurs. B. a resident wigastrostomy tube of appropriate treatments aspiration pneumor dehydration, metabout nasal-pharyngeal upossible, normal feedings. This MN Requirements by: Based on observation review, the facility from the services were proving 1 resident (R77) feedings. Finding include: On 10/27/15, at 9:5 be in bed, with the labout 10 degrees where being infused via gard on 10/27/15, at 11: observed to be lying elevated more than feeding was being in the surveyor are levation during tube.	In the comprehensive resident sing home must ensure that: Who is fed by a nasogastric or rededing syringe receives the ent and services to prevent hia, diarrhea, vomiting, solic abnormalities, and licers and to restore, if eding function. The provided to the ensure care and ided to ensure care and ided to prevent aspiration for 1 reviewed who utilized tube The same R77 was observed to HOB (head of bed) raised only while a tube feeding (TF) was astric tube (GT). The provided HOB is a same as a same and ided to the ensure care and ided to prevent aspiration for 1 reviewed who utilized tube.	2 930	Corrected			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00500				10/0		
		00522			10/2	9/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S S ROAD NO	STATE, ZIP CODE			
ST ANTH	ONY HEALTH CENT	-R	ONY, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 930	Continued From pa	ge 17	2 930				
		OB should be elevated when running, it should be at 45					
	medication adminis nurse (LPN)-A, the degrees upon enter entire time LPN-A v	7:01 to 7:04 a.m. during stration with licensed practical HOB was observed at 20 ring the room and during the was administering medication er elevated the HOB during the					
	On 10/29/15, at 9:46 a.m. R77 was dressed and lying in bed uncovered, the HOB was flat and the TF was being infused. The surveyor asked licensed practical nurse (LPN)-A about the position of R77's HOB during the TF. LPN-A verified the HOB should not be flat, and proceeded to elevate the HOB to 30 degrees. LPN-A then listened to the resident's lungs and stated, "lungs are clear."						
	had been admitted diagnoses of dysph phase, fracture of c weakness, use of C	cord indicated the resident to the facility on 3/17/14, with agia of the oropharyngeal servical vertebra, generalized GT, pulmonary embolus (blood flung function) and respiratory					
	included problem a (eating, aspiration refeeding, and Need seizures and dysphenteral feeding throincluded: "Resident date of 1/27/16)." Ir "Resident monitore	Plan last updated 5/17/15, reas of: "Nutrition Need, isk, etc.) as evidenced by tube for artificial nutrition related to agia as evidenced by need for bugh 'GT' tube." The goals to tolerate tube feeding (goal interventions included: d at meals and when taking referrals will be made:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00522	B. WING		10/2	29/ 2015
				TATE, ZIP CODE RTHEAST 121		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 930	Adjustments will be resident to decreas MD [medical doctor orders (thick liquids observed by staff a fluids; NPO [nothing 5/17/15; oral care of feeding- continue to labs per facility profappropriate; SLP [S swallow clarification via cup sip if sitting small sips and chin (water) as ordered identified the tube finterventions to dire of the bed during the high the HOB shou aspiration.	e made in the care of the te the risk of aspiration; Notify r] and obtain appropriate s, etc.) Resident to be t meals and when taking g by mouth] last updated every 2 hours; GT tube o monitor intake, weights and tocol and intervene when speech Language Pathology] n- Ok for nectar thick liquids upright and supervised. Use tuck; Provide TF and H20 " Although the care plan eeding use, there were no ect staff related to the position ne GT feeding such as, how ld be to prevent potential	2 930			
	dated 3/30/14, indic cognitive loss with a committed to stay a indicated R77 had overall activities of to assist with daily assessed to have a staff assistance with Status and Feeding had advised R77 retube feeding was be that HOB needs to running to prevent a A significant changed dated 2/17/15, with 2/20/15, lacked assiste continuous tubes	Area Assessment (CAA) cated R77 experienced delusions and had been court at the facility. The CAA experienced a deterioration in daily living and required staff cares. Although the R77 was cognitive loss, and required h daily care, the Nutritional of Tube CAA, indicated staff egarding positioning when the eing infused, "advised resident be 45 degrees while TF is aspiration." The Minimum Data Set (MDS) corresponding CAAs dated sessment information about a feeding, and lacked ection for staff about how high				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	
		00522	B. WING		10/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTH	IONY HEALTH CENTE	·R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 930	Continued From pa	ge 19	2 930			
	the HOB should be aspiration.	elevated to prevent potential				
	assessments dated the tube feeding, bu direction for staff at be elevated to preven The NA care sheet	1/15, with corresponding CAA 8/6/15, included mention of ut lacked assessment or bout how high the HOB should ent potential aspiration.				
	to indicate directions for elevation of the HOB while R77 was receiving a tube feeding.					
	On 10/29/15, at 11:11 a.m. RN-B stated the HOB should always be between 45-90 degrees to prevent risk of aspiration.					
	On 10/29/15 at 2:17 p.m., the director of nursing (DON) stated the HOB should be elevated to 45 degrees as much as tolerated. The DON stated that best practice would be to have the HOB elevated at a minimum 30 degrees to prevent aspiration.					
	dated 7/23/13, direct 4. "Resident's with o	for Tube Feeding-Enteral cted staff: continuous enteral feeding B 30 to 45 degrees at all				
	Nutrition, Special R 2009, indicated, "In research-based evi HOB elevation of 30 and pneumonia." To standard of care pro-	ety for Parenteral and Enteral eport published in January 27, summary, based on dence, authorities recommend 0°- 45° to prevent aspiration he facility failed to implement ecautions, and failed to follow d to aspiration precautions for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00522	B. WING		10/2	29/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO ONY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 930	Although a call was Medical Doctor for call. SUGGESTED MET The director of nurs develop, review, an procedures to ensur feedings have the hright height to preve DON or designee c staff on the policies designee could devensure ongoing core	placed to R77's Primary comment, there was no return THOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re residents with tube nead of the bed placed at the ent potential aspiration. The ould educate all appropriate and procedures. The DON or relop monitoring systems to	2 930			
21015	Requirements- San Subp. 7. Sanitary procedures and corthe operation of the times. This MN Requirements by: Based on observation review, the facility for procedures were for possibility of food by kitchen and hallway	O Subp. 7 Dietary Staff nitary conditions. Sanitary additions must be maintained in a dietary department at all ent is not met as evidenced on, interview and document ailed to ensure food sanitation llowed to minimize the orne illness in the main or. This had the potential to esidents who eat food out of	21015	Corrected		12/3/15

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Millinesc	nta Department of He	aim	1			,
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00522	B. WING			9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
10,1012 01 1	THO VIBERT ON COLT EIER		S ROAD NO			
ST ANTH	IONY HEALTH CENTE	-R	ONY, MN 55			
(V4) ID	SHMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IGIENGT)		
21015	Continued From pa	ge 21	21015			
	During the kitchen t	tour on 10/26/15, at 11:44 a.m.				
		bserved and confirmed by the				
	registered dietitian	(RD):				
	- the 'link' hallway b	etween the long term care				
		d living complex was				
		ith leaves, heavy dirt and dust,				
		prown/black substance along				
		e floor meets the walls. Eight				
	racks of buns and bread were on a rolling dolly in the hallway right across from an outside door that					
		e dumpster area and employee				
		hallway had numerous boxes				
		of used kitchen equipment				
		the hallway, six uncovered				
		ean resident use cups and				
		ed rolling carts with toasters				
		ereal, three rolling carts with				
		e top shelf. Two of the three				
		splatter like material on the				
		of the cover. RD stated the ed out after each meal service				
		e what the boxes of equipment				
		the hallway, open employee				
		ectly across from the open dry				
		ned a plastic container of ice				
		ted 5/20, dry Chinese noodles				
		ontainer labeled "chi noodles				
		ontainer of pancake/waffle				
		roximately 1/3 full dated 3/27,				
		lon container of molasses				
		ull, a large can of pumpkin				
		ely 1/4 of the can top with an "I don't know what they are				
	doing in here, they					
	- at the opposite en	d of the hallway directly inside				
	an open door to the	kitchen was an employee				
		wo compartment sink verified				
	by RD to be used to	rinse off food and a six foot				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00522	B. WING		10/2	29/ 2015
ST ANTHONY HEALTH CENTER 3700 FOS			DRESS, CITY, S SS ROAD NOP ONY, MN 554			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
21015	preparation table to this entire area there black/brown food d table and sink legs floor tiles. The wall compartment sink a splattered with brow wall tile across from missing. RD confirm needed cleaning, so wall tile across from missing. RD confirm needed cleaning. The sticky substance willocated on the left shottom shelving. The freezer had a builded During the follow-up 10:51 a.m. the follow verified by the adm (DD) and administrous walk in cooler had black/brown substate cooler, under all shelps. Behind a smathere was a brown Across from the stoparticles/debris little shelving. Wall behind the the heavily splattered wand around all sink there was a brown/ The garbage disposignime on the entire stated "yes I do see cleaning sheets that	o the right of the sink. Behind re was a heavy buildup of ebris on and around all the and in the grout of the back area behind the two and handwash sink was wn food material. A baseboard in the handwash sink was med this area was dirty and tating "I know, I'm aware." Foor had a heavy buildup of a lith food particles and debris side of the freezer, under the ne entrance corners to the up of a brown/black substance. To kitchen tour on 10/29/15, at wing was observed and inistrator (A), director of dining	21015			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
					c		
		00522	B. WING		10/2	9/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO				
040.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	DNY, MN 55			()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
21015	Continued From pa	ge 23	21015				
	it should be done d	aily."					
	the baseboards and equipment there was black/brown grime floors are mopped to was no deep cleani one soon."	perimeter of the kitchen along d on and around all legs of as a heavy buildup of and food debris. DD stated the two times a day and that there ing policy but "I will be making					
	- Wall behind the ice machine was splattered with a brown substance.						
	- Wall and floor to the right of the fruit juice machine was splattered with a black/brown sticky substance. Administrator stated "we need to have a deep cleaning policy."						
	During an interview on 10/29/15, at 11:15 a.m. DD stated the food found in the employee lockers was food that was taken from the dry storage to "hide it from the assisted living staff that were taking food."						
		on 10/29/15, at 12:26 p.m. in the refrigerators or freezers as you go, "It's an					
	Cleaning List week out coolers and swe 2) pull out all cookin mop floors (Tuesda cooler and frezzer [delime dishwasher mop storage room SUGGESTED MET The Administrator as	facility Miscellaneous Kitchen ly cleaning indicated "1) pull eep and mop floors (Monday), ng equipment and sweep and ay), 3) sweep and mop out sic] floors (wedesday) [sic], 4) (Thursday), 5) sweep and floor (Friday)." THOD FOR CORRECTION: and the Dietician could review vice policies and procedures					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С	
		00522	B. WING		10/2	9/2015
	PROVIDER OR SUPPLIER	3700 FOS	DRESS, CITY, S	STATE, ZIP CODE RTHEAST		
ST ANTH	ONY HEALTH CENTE	-R	ONY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 24	21015			
	manner. Staff could The Certified Dietar service of food on a	is served in a sanitary d be trained as necessary. ry Manager could monitor the a periodic basis. R CORRECTION: Twenty-				
21390		Subp. 4 A-I Infection Control	21390			12/3/15
	control program muprocedures which pare A. surveillance collection to identify residents; B. a system for control of outbreaks. C. isolation and reduce risk of trans. D. in-service exprevention and content and content in part 465 procedures of resident the prevention and F. the development of the prevention and F. the development of the products, including defined in part 465. G. a system for products which affed disinfectants, antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILDING.			;
		00522	B. WING			9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO			
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	ONY, MN 55		- N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 25	21390			
	by: Based on observati review, the facility finand washing mean residents (R43) reviaddition, the facility pen prior to attachir residents (R145) du This deficient pract	ent is not met as evidenced on, interview and document ailed to ensure appropriate sures was used for 1 of 3 iewed for morning cares. In failed to disinfect an insulining the needle for 1 of 4 uring insulin administration. ice also had the potential to esidents who utilized insulin		Corrected		
	Findings include:					
	Proper hand washing technique was not provided R43's was observed on 10/28/15, at 7:03 a.m. The bedroom door was observed door wide open and lights were out. R43 was observed lying on her back. -At 7:11 a.m. R43 when approached and asked how she had slept R43 stated had slept well but she was stiff and did not know if that was a good or bad thing. R43 indicated she had pain on her left hand and shoulder and requested for pain medication and to get out of bed. -At 7:14 a.m. surveyor reported to licensed practical nurse (LPN)-A about R43's pain and request to get up. -At 7:19 a.m. observed LPN-A administer pain medication. -At 7:34 a.m. upon entering R43's room nursing assistant (NA)-D was observed standing at R43's bedside then went to the bathroom got a wash towel came back and cued R43 she was going to wash her face. -At 7:35 a.m. another NA-E came into the room					
	indicated R43 was	in her group and was going to e day. NA-D indicated to R43				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_ ر	
		00500	B. WING		10/0	
		00522	5		10/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		3700 FOS	S ROAD NO	RTHEAST		
ST ANTE	IONY HEALTH CENTE	ER ST ANTHO	ONY, MN 55	421		
()(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21390	Continued From pa	go 26	21390			
21000	Continued i Tom pa	.ge 20	21000			
	NA-E was going to	get her ready.				
	-At 7:36 a.m. to 7:3	9 a.m. both NAs continued to				
	assist R43 with car	es and cleaned her upper				
	body including the b	pack and applied socks and				
	pants as they cued	R43.				
		cued R43 to open her legs				
	then completed per	icare in the front. Then both				
	NA's cued R43 to re	oll as NA-D cleansed her				
	bottom which was r	noted to have brown green				
	bowel movement. A	After using three wipes NA-D				
	removed the soiled	gloves and never washed her				
	hands, NA-D went	over to the dresser by the wall				
	across from R43's	bed and indicated the glove				
	box was empty, the	n reached over to her right				
	side scrubs pocket	got one glove out but never				
	applied it. NA-D the	en indicated to NA-E she was				
	going outside the d	oor to get the R43's				
	wheelchair. Still not	washed her hands NA-D left				
	the room went outs	ide the hallway wheeled R43's				
	wheelchair into the	room. Both NAs were				
	observed adjust R4	3's pants then both NA's cued				
	R43 they were goin	g to assist her to get seated at				
	the edge of bed bet	fore transferring to the				
	wheelchair. At 7:42	a.m. NA-D was observed				
	apply R43's shirt as	R43 sat on the edge of bed.				
		oth NAs standing to R43's side				
	NA-D applied a trar	nsfer belt around R43's waist				
	then cued R43 to st	tand as both NAs cued and				
	guided R43 to turn	and be seated on wheelchair.				
	NA-D then went on	to comb R43's hair and				
	applied eye glasses	s never washed hands still.				
	-At 7:49 a.m. after I	eaving R43's room NA-D was				
	observed enter roo	m 241 and that time surveyor				
	intervened and whe	en asked about hand washing.				
	NA-D acknowledge	d she had not washed her				
		ng pericare with stool observed				
		ny hands right now" as NA-D				
	entered room 241.					
	On 10/28/15, at 1:1	1 p.m. registered nurse				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				_		
		00522	B. WING		10/2	, 9/2015
					10/2	3/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	R	S ROAD NO	-		
	T		DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 27	21390			
	(RN)-F stated it was wash hands before gloves. RN-F furthe have removed glove had provided perica involved the staff whands with soap an with cares. On 10/29/15, at 9:0 manager stated wh "Staff are supposed and after removing cares, before leaving the cares, before leaving the care at the car	s the facility policy for staff to applying and after removing or stated staff was supposed to see and washed hands if they are and with stool being as supposed to wash their d water before proceeding. 7 a.m. LPN-D unit nurse en asked about hand washing to wash their hands before their gloves, before providing gethe room." Hygiene policy dated 10/8/15, equirements: ands are visibly contaminated after contact with residents. with contaminated aces adjacent to the ting residents with eating or gor assisting residents with furinals, bedpans, en, towels, wash cloths. Iter smoking or eating. In the staff of the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		71. 5012511143.		C	;	
	00522	B. WING			9/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST ANTHONY HEALTH CENTER	₹	S ROAD NO ONY, MN 55				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
needle On 10/26/15, at 7:09 set up R145's bedtim set up RN-H R145 wadraw of the medication Solostar Flexpen for obtained an AutoShiet the top of the FlexPe rubber seal with alcolinsulinAt 7:11 p.m. RN-H wafter administering of cleanse the right lower then punched the area motion gave the insurunched the area motion gave the insurunched the rubber seal RN-H acknowledged rubber seal. On 10/29/15, at 2:59 (DON) stated the nurunched the nurunched the nurunched the rubber seal instruction I will be reprotocol dated 2/2 SoloStar Instruction I will be redele. SUGGESTED METH The DON could revie and procedures relaticeleansing of the rubber seals.	p.m. RN-H was observed the medications. During the mas observed open the top on cart obtained a Lantus R145 took the cap official from a tote applied it to en without cleansing the hol and dialed 15 units of went to R145's room and ral medication was observed er abdomen area let air dry the and using constant firm the stated "I usually I top of the old insulin vial" I he should have cleaned the p.m. the director of nursing rise was supposed to cleanse as they did for the vial. In the stated staff were supposed to policy when providing cares.	21390				

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could provide education to all involved staff. The

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				(X3) DATE COMP	SURVEY LETED	
					С	
		00522	B. WING		10/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTH	IONY HEALTH CENTE	-K	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 29	21390			
	ensure ongoing cor findings to the Qual	op a monitoring system to impliance and report the lify Assurance Committee.				
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21426			12/3/15
	(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.					
	by: Based on interview facility failed to ensi tuberculosis (TB) S	ent is not met as evidenced and document review, the ure to complete Baseline creening Tool for Nursing g Care Home Residents for 5		Corrected		

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NAME OF PROVIDER OR SUPPLIER B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTHONY HEALTH CENTER 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	
21426 Continued From page 30 of 5 residents (R289, R260, R30, R283, R178). Findings include: Screening: R289 was admitted to the facility on 10/16/15, per the Minimum Data Set (MDS) entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R260 was admitted to the facility on 6/11/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R30 was admitted to the facility on 6/2/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R283 was admitted to the facility on 10/4/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R178 was admitted to the facility on 9/15/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R178 was admitted to the facility on 9/15/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. On 10/29/15, at 6:28 p.m. director of nursing (DON) stated we do not do symptom screens for residents but we do for staff. We get physician orders on admission to do 2 step mantoux on residents. If they had symptoms we would not accept them. We document in EMAR 2 step mantoux, when given, whether positive and mm of induration, 1st step given if positive, mm of induration, resident would get a chest x-ray, Facility TB Screening for Healthcare Worker	of 5 Find Screen R28 the reconstruction of 5 R28 the reconstruction of 5 R26 the Screen Care R30 MD3 Screen Care R47 the Screen Care On (DO) reside order reside accommand of interest in a construction of interest in	

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AND BLAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \					SURVEY LETED	
					С	
		00522	B. WING		10/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	policy dated 8/3/15, "4 The Tuberculosis the residents medic file based on health SUGGESTED MET director of nursing of review/revise policie Tuberculosis screet ensure the policy w	indicated: s Screen form will be placed in cal record file or appropriate a care facilities practices." THOD OF CORRECTION: The or designee, could es on resident and employee ning and perform audits to	21426			
21525	Consultation A nursing home muservices of a pharm Board of Pharmacy A. provides corprovision of pharmathome; B. establishes and disposition of a detail to enable an C. determines accurately maintain controlled drugs is	a system of records of receipt accurate reconciliation; and that drug records are ed and that an account of all	21525			12/3/15
	by: Based on observati review, the facility of ensure Fentanyl pa	on, interview, and document lid not have a system to tches were accurately nt potential diversion for 2 of 2		Corrected		

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STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
		00522	B. WING		10/2	; 9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	R	S ROAD NO	-		
	T	SIANIHO	DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21525	Continued From pa	ge 32	21525			
	Findings include:					
	1 East Unit On 10/27/15, at 2:1 medication cart was nurse (RN)-G who periodication cart and narcotic box to the box of Fentanyl pate what the facility pro- used patches RN-G the destruction and and disposed it in the medication room. Residually been discontinued b	s completed with registered provided access to the difference of the narcotic box. Inside the back was observed an opened ches for R53. When asked cedure was for destroying a stated two nurses completed would cut up patch in pieces he black box located in the tin-G stated the patch had nowever indicated she was where both nurses would githe used patches. approached stated she was he documentation for the patch allowed practical nurse led access to the cart and the the medication cart to the se of Fentanyl patched for he four and three patches left reviewing the narcotic book it was only one nurse signature asked what the facility policy the used patches, LPN-E e would witness when he however neither of the difference of the difference of the was done as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:						
		00522	B. WING		10/2) 19/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	HONY HEALTH CENTE	-K	S ROAD NO ONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21525	Continued From pa	ge 33	21525			
	indicated R145 had	Orders dated 10/29/14, I an order for the Fentanyl microgram (mcg)/hour (patch				
		ncluded trauma leg c pain, neuropathy and gout terly Minimum Data Set (MDS)				
	Administration Recthrough 10/29/15, it Fentanyl patch remtimes with only one be determined if the one nurse signed o	145's Electronic Medication ord (EMAR) dated 10/1/15, twas revealed R145 had the oved and disposed of ten nurse signing off. It could not ere were two nurses as only ff for applying of the Fentanyl n/removal documentation.				
		Orders dated 10/29/15, I an order for the Fentanyl mcg/hour.				
	left hip, age related rheumatica and his	ncluded chronic pain, pain in osteoporosis, polymyalgia tory of traumatic fracture sheet dated 10/29/15.				
	Administration Recthrough 10/29/15, it Fentanyl patch rem times with only one be determined if the one nurse signed opatch no destructio On 10/29/15, at 2:5 (DON) stated she waware of the form the statement of	124's Electronic Medication ord (EMAR) dated 10/1/15, it was revealed R124 had the oved and disposed of ten nurse signing off. It could not ere were two nurses as only ff for applying of the Fentanyl n/removal documentation. 19 p.m. the director of nursing was not aware nurses were not hey needed to complete when I patches. DON stated the				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STANTHONY HEALTH CENTER STANTHONY HEALTH CENTER STANTHONY HEALTH CENTER STANTHONY MN 5421 [PAPER CACHO PERFCIENCY NUEST SE PERCECED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFEX CACHO PERFCIENCY NUEST SE PERCECED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) On 10/29/15, at 3:31 p.m. on a telephone conversation the consultant pharmacist stated, "Yes they should be documenting two nurses for the destruction of the patches. I know there is a form from the pharmacy" when asked what his expectation was of the facility with destruction of Fentanyl patches to prevent diversion. Medication Administration policy dated 12/12, did not address Fentanyl destruction and facility procedures for nurses. In addition, the policy did not indicate who was responsible to oversee, if nurses were consistently documenting Fentanyl patch disposal to prevent potential diversion. Controlled Medications Storage policy dated 12/12, directed "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations." The policy did not indicate who was responsible for ensuring the Fentanyl patches were signed off when destroyed to prevent potential diversion. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STANTHONY HEALTH CENTER STANTHONY, MN 55421 (X4) ID (X5) ID (X5) ID (X6) ID				A. BOILDING.		ے ا	
STANTHONY HEALTH CENTER (A4) ID PREFIX TAGE (BACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE (BACH DEFICIENCY) 21525 Continued From page 34 facility had a form for destruction. On 10/29/15, at 3:31 p.m. on a telephone conversation the consultant pharmacist stated, "Yes they should be documenting two nurses for the destruction of the patches. I know there is a form from the pharmacy" when asked what his expectation was of the facility with destruction of Fentanyl patches to prevent diversion. Medication Administration policy dated 12/12, did not address Fentanyl destruction and facility procedures for nurses. In addition, the policy did not indicate who was responsible to oversee, if nurses were consistently documenting Fentanyl patch disposal to prevent potential diversion. Controlled Medication Stroage policy dated 12/12, directed "Medication Stroage policy dated 12/12, directed "Medication Stroage policy dated 12/12, directed "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations." The policy did not indicate who was responsible for ensuring the Fentanyl patches were signed off when destroyed to prevent potential diversion. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and			00522	B. WING			
XAI DIA SUMMARY STATEMENT OF DEFICIENCIES DIA PROVIDER'S PLAN OF CORRECTION (ICACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRIEFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21525 Continued From page 34 facility had a form for destruction. 21525 Continued From page 34 facility had a form for destruction. Con 10/29/15, at 3:31 p.m. on a telephone conversation the consultant pharmacist stated, "Yes they should be documenting two nurses for the destruction of the patches. I know there is a form from the pharmacy" when asked what his expectation was of the facility with destruction of Fentanyl patches to prevent diversion. Medication Administration policy dated 12/12, did not address Fentanyl destruction and facility procedures for nurses. In addition, the policy did not indicate who was responsible to oversee, if nurses were consistently documenting Fentanyl patch disposal to prevent potential diversion. Controlled Medication Storage policy dated 12/12, directed "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations." The policy did not indicate who was responsible for ensuring the Fentanyl patches were signed off when destroyed to prevent potential diversion. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFIDIENCY MIST BE PRECIDED BY FULL REGULATORY OF LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG	ST ANTI	HONY HEALTH CENTE	-R				
facility had a form for destruction. On 10/29/15, at 3:31 p.m. on a telephone conversation the consultant pharmacist stated, "Yes they should be documenting two nurses for the destruction of the patches. I know there is a form from the pharmacy" when asked what his expectation was of the facility with destruction of Fentanyl patches to prevent diversion. Medication Administration policy dated 12/12, did not address Fentanyl destruction and facility procedures for nurses. In addition, the policy did not indicate who was responsible to oversee, if nurses were consistently documenting Fentanyl patch disposal to prevent potential diversion. Controlled Medication Storage policy dated 12/12, directed "Medication Storage policy dated 12/12, directed "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations." The policy did not indicate who was responsible for ensuring the Fentanyl patches were signed off when destroyed to prevent potential diversion. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and	PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
procedures to ensure compliance. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21525	facility had a form for the conversation the conversation the conversation the conversation the destruction of the destruction of the destruction was of the form from the pharmal expectation was of the fentanyl patches to the Medication Administration address Fentanyl patches for nursing the disposal to procedure for nursing the fentanyl patch disposal to proceed the fentanyl patched in	or destruction. If p.m. on a telephone onsultant pharmacist stated, e documenting two nurses for the patches. I know there is a macy" when asked what his the facility with destruction of or prevent diversion. It ration policy dated 12/12, did nyl destruction and facility ses. In addition, the policy did as responsible to oversee, if stently documenting Fentanyl revent potential diversion. In Storage policy dated 12/12, ns included in the Drug phistration (DEA) classification ance are subject to special disposal and record keeping in enter in accordance with other applicable laws and olicy did not indicate who was uring the Fentanyl patches en destroyed to prevent THOD OF CORRECTION: Sing (DON) or designee could indor revise policies and ure compliance. The director of esignee could educate all in the policies and procedures. Sing (DON) or designee could systems to ensure ongoing	21525			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		_	
		00522	B. WING		10/2	
		00522	2		10/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO			
		ST ANTHO	ONY, MN 55	421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 35	21545			
21545	MN Rule 4658.1320	A.B.C Medication Errors	21545			12/3/15
	percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refepurposes of this pa (1) a discrepair prescribed and what administered to resect (2) the administered to require the medications. B. It is free of a sect (2) medication error (2) medication error discomfort or jeopal safety; or (2) medication error confective the medication error confective the medication error report must be that occurs. Any significant reactions or physician or the phyresident or the resident or the reside	ast ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For art, a medication error means: act medications are actually idents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident redizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single uld alter that level and urrence of symptoms or ions are administered as ident report or medication error guificant medication errors or must be reported to the ysician's designee and the dent's legal guardian or ntative and an explanation e resident's clinical record. ons are administered as dent report or medication error for any medication error that cant medication errors or				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			;
		00522	B. WING			9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO			
	OLIMANA DV. OTA		ONY, MN 55		<u></u>	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	.D BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 36	21545			
	physician or the phyresident or the resident designated represe	nust be reported to the ysician's designee and the dent's legal guardian or ntative and an explanation e resident's clinical record.				
	by: Based on observati review, the facility f (R145) who utilized observed for medic	ent is not met as evidenced on, interview, and document ailed to ensure 1 of 4 residents insulin FlexPen device ation administration was free s. The medication error rate		Corrected		
	Findings include:					
	indicated R145 had	Orders dated 10/29/14, an order for Glargine insulin units) subcutaneous two etes type II.				
	(RN)-H was observed medications. During observed open the cart obtained a Lan took the cap off obtatote applied it to the cleansing the rubbe insulin never prime insulin to pre-fill the -At 7:11 p.m. RN-H after administering cleanse the right lot then punched the amotion gave the insulin sulin gave the insulin to pre-fill the control of the control	went to R145's room and oral medication was observed wer abdomen area let air dry rea and using constant firm				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00522	B. WING			9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3700 FOS	S ROAD NO	RTHEAST		
ST ANTH	ONY HEALTH CENTE	-R	ONY, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	THATE	DAIL
21545	Continued From pa	ne 37	21545			
	was for priming the insulin pens RN-H stated "When I was trained here I was never told about priming. I will check on that."					
	priming. I will check	Con mai.				
	On 10/27/15, at 8:3	1 a.m. licensed practical nurse				
		ved obtained the Lantus				
		R145 took off the cap donned				
		ened the alcohol wrap wiped				
		ne FlexPen applied the				
		dialed the pen to 15 units of				
	insulin. As LPN-E was going into R145's room to administer insulin surveyor intervened, asked of					
		ne manufacturer instructions				
		lin pen, LPN-E stated she had				
		exPen before. LPN-E left the				
		e nursing station and was				
		at the instructions were and				
		ation RN-F appeared confused				
		veyor meant by priming the				
	pen.	nurse manager stated usually				
		st supposed to dial to the				
		rdered for the resident.				
		yor and both nurses walked				
		RN-F repeated to surveyor				
	nurses were suppor	sed to dial to the amount				
		ed. When asked what the				
		ctions were again RN-F				
		nd out from the pharmacist.				
		rector of nursing (DON) stated				
		what you mean by priming the the nurses to dial up the				
		Then surveyor was explaining				
		ON then stated "I now know				
	what you mean."	The state of the s				
		stated all nurses should have				
	known the Flexpen	was supposed to be primed				
		facturer instructions for the				
		cated the device was				
	supposed to be pre	-filled with two units.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPL	
		00522	B. WING		10/2	; 9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, §	STATE, ZIP CODE		
OT ANTI	IONIVIUE ALTU OFNITI	3700 FOS	S ROAD NO			
STANTE	IONY HEALTH CENT	ST ANTHO	ONY, MN 55	421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
21545	Continued From pa	ıge 38	21545			
	instructions then af	was observed give LPN-E iter LPN-E completed the correctly with DON and				
	he did not administ answer to it. When expected 12 units t agreed and added	56 p.m. medical director stated ter medications and would not asked if he would have to be delivered as ordered MD "if you're asking if there would or got 10 or 14 units, no."				
	consultant pharmac prime the pens acc instructions" when nurses were suppo	30 p.m. via phone the cist (CP) stated "They should cording to the manufacturer's the CP was asked if the esed to prime the pens with two re-fill the syringe prior to amount.				
	March 2007 from S directed staff to: "Step 3. Perform a Always perform the injection. Performin you get an accurate ensuring that performing air but a Select a dose of selector. B. Take off the outer remove the used not the inner needle cat C. Hold the pen wit D. Tap the insulin rebubbles rise up tow E. Press the injection.	e Safety test before each ing the safety test ensures that it e dose by: wen and needle work properly subbles 2 units by turning the dosage it is each after injection. Take off it is and discard it. It is needle pointing upwards eservoir so that any air wards the needle.				
	if insulin comes out You may have to pe	t of the needle tip. erform the safety test several				

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Minneso	<u>ta Department of He</u>	alth			_	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00522	B. WING		10/2	; 9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CT ANTL	IONV HEALTH CENTS	3700 FOS	S ROAD NO	RTHEAST		
STANIF	IONY HEALTH CENTE	ST ANTHO	ONY, MN 55	421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 39	21545			
	and repeat the safe remove them. If still no insulin be blocked. Change If no insulin corneedle, your SoloSi use this SoloStar." SUGGESTED MET The director of nursand/or revise facility related to medication significant medication transcription process could be re-educate procedures. The mindividual(s) identification reviewed for accurate supporting docume investigation could root cause of this significant regiment evaluated for approand administration. developed and impution with the facility's Quantum Assurance committic compliance.	ris seen. The sout, check for air bubbles the test two more times to comes out, the needle may the the needle and try again. The sout after changing the tar® may be damaged. Do not the test of the t				
21610	MN Rule 4658.1340 and Preparation Are	Subp. 1 Medicine Cabinet ea;Storage	21610			12/3/15

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00522	B. WING			9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	IONY HEALTH CENT	-R	S ROAD NO ONY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 40	21610			
	Subpart 1. Storage must store all drugs under proper temper	of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have				
	by: Based on observati review, facility failed medication carts or	on, interview and document d to ensure that 2 of 2 in the subacute unit were e potential to affect 19 of 27 b acute unit.		Corrected		
	Findings include:					
	10/28/15, at 9:01 a. one was left unlock (RN)-D walked aware-9:02 a.m. a therap resident passed the -9:03 a.m. nursing a cart9:04 a.m. RN-A resat at the desk and -9:05 a.m. a house medication cart9:07 a.m. a therap medication cart9:08 a.m. a female medication cart. No visible in hallway.	tinuous observation on m. sub acute medication cart ed when registered nurse by toward the front lobby. It is staff member and male equilibrium unlocked medication cart. It is assistant (NA)-A passed the sturned to the nursing unit and printed out papers. It is weeper passed unlocked by staff member past the equilibrium eresident passed the unlocked on nurse was at the desk or turned to medication cart one				
	10/28/15, at 9:16 a.	tinuous observation on m. sub acute medication cart ed when RN-E went into an				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
		00522	B. WING			C 29/2015
	PROVIDER OR SUPPLIER	3700 FOS	DDRESS, CITY, S SS ROAD NOI ONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21610	-9:18 a.m. RN-D locart two. During interview on verified that medical unlocked. RN-D state contained blood premedication for treat sugars), coumading creams. During interview on subacute nurse masshould be locked if nurse should at lead RN-C stated it would medication carts undesk or if their backed. If don't usual unlocked. I wanted him about a resider During interview on director of nursing is medication cart is of should be locked. If across hall from calcan be unlocked. The director of nursing is should be locked. If across hall from calcan be unlocked. The director of nursing interview on director of nursing is should be locked. The dir	cked sub acute medication 10/28/15, at 9:09 a.m. RN-D ation cart one was left ated the medication carts essure medications, insulin (a ment of elevated blood (a blood thinner) and various 10/28/15, at 9:35 a.m. RN-C nager stated a medication cart out of the nurses reach. The st be able to see the cart. Id not be ok to have allocked while sitting at the cato it. 10/28/15, at 9:40 a.m. RN-E ally leave my medication cart to catch the doctor to update				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00522	B. WING		10/2	9/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTI	ONY HEALTH CENTE	R	S ROAD NO ONY, MN 55	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	procedures to ensurappropriately stored (DON) or designee staff on the policies of nursing (DON) or monitoring systems compliance. TIME PERIOD FOR (21) Days.	re medications are d. The director of nursing could educate all appropriate and procedures. The director r designee could develop to ensure ongoing R CORRECTION: Twenty-one	21610			
21735	Solid wastes, include recyclables, and off stored, and dispose create a nuisance of breeding place for it. Accumulation of counassigned areas in This MN Requirements. This MN Requirements by: Based on observation review, the facility for containment of gard to prevent attracting area observed. Findings include: During the initial kit. 11:44 a.m. with the brown dead rat was outside dumpster. Fright away." To the	mbustible material or waste in s prohibited. ent is not met as evidenced on, interview and document ailed to ensure proper page in the outside dumpsters pests for 1 of 1 trash storage observed dietitian (RD), a sobserved behind the large RD stated "I will tell someone right of the dumpster there	21735	Corrected		12/3/15
	right away." To the were two plastic ba ground next to a re-					

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PRINTED: 11/30/2015

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00522 10/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY HEALTH CENTER ST ANTHONY, MN 55421 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

21735

6899

control company comes onsite every month and it was the first rat he was aware of in the 11 years he worked at the facility. MD stated there have not been any pests inside the facility per the pest control company reports. Review of the pest Service Inspection Reports from 12/16/14 thru 9/23/15, indicated there was

During an interview on 10/28/15, at 9:03 a.m. the maintenance director (MD) stated an outside pest

away from the dumpster and dead rat, however only four feet from the door entrance where employees took out the trash and had access to an employee smoking area. RD stated "I don't know where that came from" and verified the trash bags should have been in the outside

outside near the dumpster area. No garbage containment policy was provided.

no pest activity inside the facility with 3 of 11 reports indicating a house mouse was located

SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop, review, and/or revise policies and procedures to ensure the proper storage and disposal of garbage is maintained. The maintenance director or designee could educate all appropriate staff on the policies and procedures. The maintenance director or designee could develop monitoring systems to

TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.

ensure ongoing compliance.

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Continued From page 43

dumpster and not on the ground.

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00522	B. WING			9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21805	Continued From pa	ge 44	21805			
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			12/3/15
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview and document alled to ensure 4 of 5 residents (2291) cares were provided in a		Corrected		
	Findings include:					
	cataract, mild cogni Osteoporosis, mus	cle weakness, major eoarthritis obtained from form				
	The bedroom door and lights were out her backAt 7:11 a.m. R43 whow she had slept I she was stiff and di or bad thing. R43 ir left hand and should medication and to g-At 7:14 a.m. surve practical nurse (LPI request to get up.	d on 10/28/15, at 7:03 a.m. was observed door wide open R43 was observed lying on when approached and asked R43 stated had slept well but d not know if that was a good adicated she had pain on her der and requested for pain get out of bed. yor reported to licensed N)-A about R43's pain and wed LPN-A administer pain				

6899

Minnesc	<u>ota Department of He</u>	aith				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
					C	
		00522	B. WING			
		00322			10/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3700 FOS	S ROAD NO	RTHFAST		
ST ANTH	IONY HEALTH CENTE	-D	ONY, MN 55			
	0.11.11.15./.07.4					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
		•		DEFICIENCY)		
21805	Continued From pa	ge 45	21805			
	-Δt 7:34 a m μηση	entering R43's room nursing				
		as observed standing at R43's				
		to the bathroom got a wash				
		nd cued R43 she was going to				
		acy curtain was not pulled				
	around the bed.	acy curtain was not pulled				
		entered the room indicated				
		up and was going to get her				
	ready for the day.	O a man la atla NIA la vuerra				
	-At 7:36 a.m. to 7:39 a.m. both NA's were					
		R43's hospital gown and				
		her upper body including the				
		the area did not cover R43.				
		socks and pants half way. Still				
	R43's breast expos					
		cued R43 to open her legs				
		icare in the front. Then both				
		oll as NA-D cleansed her				
		ved the soiled gloves and				
		nands, went over to the				
		across from R43's bed and				
		box was empty, then reached				
		e scrubs pocket got one glove				
		ed it. NA-D then indicated to				
		g outside the room to get				
		IA-D left the room went				
	1	left the door wide open as				
		at resident bed applying the				
		n resident breast still exposed				
		not pulled. Surveyor followed				
		see R43's entire body when				
		way looking into the room.				
		R43's wheelchair into the				
		. Both NAs were observed				
	adjust R43's pants	then cued R43 they were				
	going to assist her	to get seated at the edge of				
		ring to the wheelchair.				
		was observed apply R43's				
	shirt as R43 sat on					
		oth NAs standing to R43's				

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NAME OF PROVIDER OR SUPPLIER STANTHONY HEALTH CENTER 370 FOSS ROAD NORTHEAST STANTHONY, MN 55421 [XA) ID PREFIX TAG CHOOSE ROAD NORTHEAST STANTHONY, MN 55421 21805 COntinued From page 46 sides NA-D applied a transfer belt around R43's waist then cued R43 to stand as both NAs cued and guided R43 to turn and be seated on wheelchair. On 10/28/15, at 7:59 a.m. NA-E verified R43's breast had not been covered during the entire time cares were provided and even when NA-D was bringing the wheelchair into the room. Wheelchair was being brought into the room NA-E stated 'usually her cares go a lot faster and I don't have to leave the room. Yes it should have been pulled.' On 10/28/15, at 7:51 a.m. R43 was observed seated on her wheelchair the to was a strong or and to cover a resident skin that was not being cleaned with like a towel and staff was supposed to pull the privacy curtain was personal cares and to cover a resident skin that was not being cleaned with like a towel and staff was supposed to pull the privacy curtain. On 10/28/15, at 1:11 p.m. registered nurse (RN)-F stated she would expect staff to have a resident skin that was not being cleaned with like a towel and staff was supposed to pull the privacy curtain. On 10/28/15, at 6:51 a.m. R43 was observed seated on her wheelchair at the dining room table. When asked if it bother her when staff exposed her body when receiving personal cares R43 stated 'I get cold id on't like people seeing me naked.'' On 10/29/15, at 6:51 a.m. LPN-D nurse manager stated 'It is a dignity thing we knock at the door and when we are providing cares staff should cover the area they are not working on. Staff should not expose residents and be mindful of the weather and being cold. Staff are also.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES ST ANTHONY, MN 55421 21805 Continued From page 46 sides NA-D applied a transfer belt around R43's waist then cued R43 to stand as both NAs cued and guided R43 to turn and be seated on wheelchair. On 10/28/15, at 7:59 a.m. NA-E verified R43's breast had not been covered during the entire time cares were provided and even when NA-D was bringing the wheelchair into the room. When asked if the privacy curtain was supposed to be pulled for privacy during cares and when wheelchair was being brought into the room NA-E stated "usually her cares go a lot faster and I don't have to leave the room. Yes it should have been pulled." On 10/28/15, at 1:11 p.m. registered nurse (RN)-F stated she would expect staff to have a resident body exposed minimally during cares and to cover a resident skin that was not being cleaned with like a towel and staff was supposed to bull the privacy curtain. On 10/29/15, at 6:51 a.m. R43 was observed seated on her wheelchair at the dining room table. When asked if it bother her when staff exposed her body when receiving personal cares R43 stated "1 get cold I don't like people seeing me naked." On 10/29/15, at 10:36 a.m. LPN-D nurse manager stated "1 is a dignity thing we knock at the door and when we are providing cares staff should cover the area they are not working on. Staff should not exposer residents and the mindful				A. BOILDING.			
STANTHONY HEALTH CENTER 3700 FOSS ROAD NORTHEAST STANTHONY, MIN 55421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES) (REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX TAG (REACH CORRECTIVE ACTION SHOULD BE REQUIATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE OF THE APPROPRIATE DAT			00522	B. WING			-
X4 ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XX) PREFIX TAG 21805 Continued From page 46 Sides NA-D applied a transfer belt around R43's waist then cued R43 to stand as both NAs cued and guided R43 to turn and be seated on wheelchair. On 10/28/15, at 7:59 a.m. NA-E verified R43's breast had not been covered during the entire time cares were provided and even when NA-D was bringing the wheelchair into the room. When asked if the privacy curtain was supposed to be pulled for privacy during cares and when wheelchair was being brought into the room NA-E stated "susually her cares go a lot faster and I don't have to leave the room. Yes it should have been pulled." On 10/28/15, at 1:11 p.m. registered nurse (RN)-F stated she would expect staff to have a resident body exposed minimally during cares and to cover a resident skin that was not being cleaned with like a towel and staff was supposed to pull the privacy curtain. On 10/29/15, at 6:51 a.m. R43 was observed seated on her wheelchair at the dining room table. When asked if it bother her when staff exposed her body when receiving personal cares R43 stated "I get cold I don't like people seeing me naked." On 10/29/15, at 10:36 a.m. LPN-D nurse manager stated "It is a dignity thing we knock at the door and when we are providing cares staff should cover the area they are not working on. Staff should not expose residents and be mindful	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRIEFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 21805 Continued From page 46 sides NA-D applied a transfer belt around R43's waist then cued R43 to stand as both NAs cued and guided R43 to turn and be seated on wheelchair. On 10/28/15, at 7:59 a.m. NA-E verified R43's breast had not been covered during the entire time cares were provided and even when NA-D was bringing the wheelchair into the room. When asked if the privacy curtain was supposed to be pulled for privacy during cares and when wheelchair was being brought into the room NA-E stated "usually her cares go a lot faster and I don't have to leave the room. Yes it should have been pulled." On 10/28/15, at 1:11 p.m. registered nurse (RN)-F stated she would expect staff to have a resident body exposed minimally during cares and to cover a resident stody exposed minimally during cares and to cover a resident stody exposed minimally during cares and to cover a resident staff was supposed to pull the privacy curtain. On 10/29/15, at 6:51 a.m. R43 was observed seated on her wheelchair at the dining room table. When asked if it bother her when staff exposed her body when receiving personal cares R43 stated "I get cold I don't like people seeing me naked." On 10/29/15, at 10:36 a.m. LPN-D nurse manager stated "It is a dignity thing we knock at the door and when we are providing cares staff should cover the area they are not working on. Staff should not expose residents and be mininful	ST ANTH	ONY HEALTH CENT	- L				
sides NA-D applied a transfer belt around R43's waist then cued R43 to stand as both NAs cued and guided R43 to turn and be seated on wheelchair. On 10/28/15, at 7:59 a.m. NA-E verified R43's breast had not been covered during the entire time cares were provided and even when NA-D was bringing the wheelchair into the room. When asked if the privacy curtain was supposed to be pulled for privacy during cares and when wheelchair was being brought into the room NA-E stated "usually her cares go a lot faster and I don't have to leave the room. Yes it should have been pulled." On 10/28/15, at 1:11 p.m. registered nurse (RN)-F stated she would expect staff to have a resident body exposed minimally during cares and to cover a resident skin that was not being cleaned with like a towel and staff was supposed to pull the privacy curtain. On 10/29/15, at 6:51 a.m. R43 was observed seated on her wheelchair at the dining room table. When asked if it bother her when staff exposed her body when receiving personal cares R43 stated "I get cold I don't like people seeing me naked." On 10/29/15, at 10:36 a.m. LPN-D nurse manager stated "It is a dignity thing we knock at the door and when we are providing cares staff should cover the area they are not working on. Staff should not expose residents and be mindful	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	COMPLETE
supposed to pull the privacy curtain with cares all the time that is my expectation."	21805	sides NA-D applied waist then cued R4 and guided R43 to wheelchair. On 10/28/15, at 7:5 breast had not bee time cares were prowas bringing the whasked if the privacy pulled for privacy dwheelchair was beistated "usually her don't have to leave been pulled." On 10/28/15, at 1:1 (RN)-F stated she resident body expoand to cover a resident body expoand to cover a resident with like a to pull the privacy of the weather and supposed to pull the stated "I get come naked."	I a transfer belt around R43's 3 to stand as both NAs cued turn and be seated on 59 a.m. NA-E verified R43's in covered during the entire poided and even when NA-D heelchair into the room. When wourtain was supposed to be uring cares and when ing brought into the room NA-E cares go a lot faster and I the room. Yes it should have 1 p.m. registered nurse would expect staff to have a sed minimally during cares dent skin that was not being towel and staff was supposed curtain. If a.m. R43 was observed elchair at the dining room if it bother her when staff when receiving personal cares old I don't like people seeing 136 a.m. LPN-D nurse is a dignity thing we knock at we are providing cares staff the at hey are not working on. pose residents and be mindful being cold. Staff are also e privacy curtain with cares all		DETIGIENCT)		

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00522	B. WING		10/2	; !9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTI	HONY HEALTH CENTI	-R	S ROAD NO ONY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	(DON) stated she was provide for privacy was a dignity concern. Activities of daily live Assessment (CAA) required extensive bathing and person. R77's diagnoses in schizophrenia and feeding (TF) obtain Data Set (MDS) da. On 10/29/15, at 7:0 observed set R77's -At 7:11 a.m. both I room to observe m gastrostomy tube (was going to admir Upon entering room eye closed and the approximately 20 d medication on the bathroom, obtained (measuring device) then disconnected end with alcohol har resident she was gothen after administed During the entire of open and the privace length of the roomrous -At 7:16 a.m. R77's came around and pathere briefly then was walked past R77's	would have expected staff to during cares. Acknowledged ern. ring (ADL's) Care Area dated 2/5/15, indicated R43 assistance with dressing lal hygiene. cluded depression, use of gastric tube (GT) (tube ed from the quarterly Minimum ted 8/11/15. If to 7:10 a.m. LPN-A was medications. LPN-A and surveyor went to edication administration via GT). LPN-A stated to R77 she dister morning medications. In, R77 was lying on her back, head of bed was at egrees. LPN-A set the bedside pull table went to the divater in a cylinder and applied gloves. LPN-A the tube feeding cleansed the langit up on the pool. Stated to be only to listen to her stomach dered medications via GT. Deservation time door was wide by curtain was pulled to the	21805			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
					С	
		00522	B. WING		10/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	3700 FOS	S ROAD NO	RTHEAST		
OI AIIII	IONT HEALIN OLIVIE	ST ANTHO	ONY, MN 55	421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 48	21805			
	she had neither clo privacy curtain duri stated it was suppo provide R77 privacy	•				
	stated, "If the reside	9 p.m. the director of nursing ent was exposed she would nurse to have shut the door acy curtain."				
	requested but the d	4 p.m. a dignity policy was lirector of nursing stated "We ty policy. We follow the				
	R289 was severely required assistance indicated R289 was bowel and bladder.	MDS dated 10/23/15, indicated cognitively impaired and with all ADLs. R289's MDS frequently incontinent of R289's MDS included and depression.				
	a.m. until 10:47 a.m7:06 a.m. Residen -7:38 a.m. Nursing R289's room and si -7:39 a.m. NA-A lef -7:40 a.m. NA-C kn entered the room wacknowledgement7:42 a.m. Explaine and encouraged R2 "I am afraid." NA-C	t was sleeping in room. assistant (NA)-A entered tated it was time to get up. t to get help. urned to R289's room. ocked on the door and				

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Minneso	<u>ta Department of He</u>	ealth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00522	B. WING		1 0/2) 9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		3700 FOS	S ROAD NO	•		
STANIF	IONY HEALTH CENTE	ST ANTHO	ONY, MN 55	421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 49	21805			
	wash R289's bottor and just held NA-C'-7:51 a.m. NA-A an tell the nurse R289 instructed R289 to assistance when re R289 lying in bed of face appeared district trembling. clutching am so frightened." I socks and black slaup legs. Incontinent R289's buttocks8:09 a.m. Residenthand clenched on service a.m. NA-A an without knocking. Nother up." NA-B hand encouraged R289 to doing a good job underarms washed "see [R289] doesn't -8:34 a.m. RN-D know waiting for a resport to get up for breakf. NA-A rolled his heaceiling8:51 a.m. RN-D Leis where the fight is was up and dressed breakfast. During interview on stated, "I thought I is today."	n. R289 would not turn over s hand. d NA-C told R289 they would did not want to get up. NA-A use call light to call for ady to get up and left room. overed with a sheet. R289's essed, eyes narrowed, lips top of sheet. R289 stated "I Resident had on red anti slip acks that were partially pulled be pad was open under t lying on bed staring at ceiling sheets. d NA-B entered R289's room lA-A and NA-B informed R289 to get R289 up for breakfast. B, "The nurse said she will get led R289 a wash cloth and o wash face and praised R289 b. R289 refused to have.				
		vous I must have forgotten to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00522	B. WING		10/2	29/ 2015
ST ANTHONY HEALTH CENTER 3700 FOS		DRESS, CITY, S S ROAD NOI ONY, MN 554				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	knock." During interview on DON stated she ex for a response before stated she would not resident comments. R291's Face Sheet R291 diagnoses in communicating) an Sheet printed 10/28 R291's blood sugar. During a blood sugar. During a blood sugar. During a blood sugar. During a blood sugar. Explained the proceglucometer (a mack sugars) bucket downwithout a barrier beto bed table. LPN-B water off. LPN-B clewipe and allowed to put on clean gloves alcohol wipe. LPN-loff the first drop of on test strip. LPN-E barrier. Cleaned glet dry. LPN-B wrap and put it in the buand washed hands. During the entire proceguring the entire process.	10/29/15, at 2:35 p.m. the pected staff to knock and wait ore entering a room. The DON of expect staff to roll head at I printed 10/29/15, indicated cluded aphasia (difficulty diabetes. Physician Order 8/15, instructed staff to check is four times a day. ar observation on 10/29/15, at intered R291's room and edure. LPN-B put the hine for checking blood on on over the bed table atween the bucket and over the rashed hands and turned the eaned glucometer with a PDI of dry for two minutes. LPN-B is, wiped R291's finger with an B pricked R291's finger with an B pricked R291's finger, wiped blood and took a drop of blood a put the glucometer down on ucometer with PDI wipes and oped glucometer in paper towel cket. LPN-B removed gloves, turning off facet with bare	21805			

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00522	B. WING			C 10/29/2015	
NAME OF I		00522			10/2	9/2015	
	PROVIDER OR SUPPLIER	3700 FOS	S ROAD NO	STATE, ZIP CODE RTHEAST			
ST ANTH	IONY HEALTH CENTE	-R	ONY, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21805	Continued From pa	ge 51	21805				
	acknowledged, "I di checking the blood The facility's Our Pl form undated direct	10/29/15, at 4:45 p.m. LPN-B id not shut the door while sugar. I should have." atinum Service Standards ted staff be considerate and dignity and respect.					
	The administrator of	THOD OF CORRECTION: or social services could n the residents rights so they or each resident.					
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen					
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			12/3/15	
	residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve their sical and mental functioning. where the service is not blic or private resources.					
	by: Based on observati review, the facility for	ent is not met as evidenced on, interview and document ailed to ensure call lights were 3 residents (R77) reviewed for		Corrected			

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		С	
		00522	B. WING			9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 52	21810			
	incontinence and w call light.	ho were capable of using the				
	Findings include:					
	observation the cal on the other side of Both registered nur the call light was not a 10:00 a.m. whe the call light R77 shasked to demonstrated light on as the cother strings which her call light. On 10/29/15, at 2:5 stated the call light	n asked if she was able to use nook her head and when ate R77 was not able to put the cord was wrapped up with made it hard for her to use 19 p.m. the director of nursing was supposed to be at reach				
	R77's diagnoses in general muscle we	cluded abnormality of gait, akness, major depression and irment obtained from the care 1/6/15.				
	R77 at risk for fall a with neck injury. Th keep "Call light with enabler bar." In add "Resident has also light for assistance	falls dated 11/6/15, identified as evidenced by history of fall the care plan directed staff to the nin reach [left] (L) side bed dition the care plan indicated been reminded to use her call with any needs and she anding to the counsel."				
	requested but was SUGGESTED MET The director of nurs	0 p.m. the call light policy was not provided. HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00522	B. WING		C 10/29/2015	
	PROVIDER OR SUPPLIER	3700 FOS	DRESS, CITY, S S ROAD NO ONY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21810	resident reach. The designee could edu the policies and pronursing (DON) or d monitoring systems compliance.	re call lights are kept within director of nursing (DON) or locate all appropriate staff on locedures. The director of esignee could develop	21810			
21980	Subd. 3. Timing of reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explains information to the condividual is a vulnerable the individual is a dreporter is not require maltreatment of the to admission, unless (1) the individual was another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in this	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult eysical injury which is not ed shall immediately report the formon entry point. If an erable adult solely because enitted to a facility, a mandated irred to report suspected enidividual that occurred prior is: as admitted to the facility from the reporter has reason to be adult was maltreated in the mows or has reason to believe a vulnerable adult as defined et, subdivision 21, clause (4). required to report under the ection may voluntarily report	21980			12/3/15

Minnesota Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		С	
		00522	B. WING			, 9/2015
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST ANTHO	ONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
	been made to the c (d) Nothing in this reporter from also r agency. (e) A mandated r reason to believe th 626.5572, subdivisi (5), occurred must r subdivision. If the r time believes that a agency will determine the reported error with erriteria under set 17, paragraph (c), of facility may provided directly to the lead a how the event meet 626.5572, subdivisi (5). The lead ageninformation when make the report under sufficiently failed to ensure the report under sufficiently failed to ensure the removed for incider sufficiently failed to ensure the face of the fac	on to know that a report has ommon entry point. It is section shall preclude a reporting to a law enforcement reporter who knows or has not an error under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any in investigation by a lead ne or should determine that was not neglect according to rection 626.5572, subdivision clause (5), the reporter or agency information explaining its the criteria under section on 17, paragraph (c), clause not shall consider this making an initial disposition of bidivision 9c. The portion of the administrator shall for 1 of 4 residents (R55)	21980	Corrected		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00522	B. WING		10/2	9/2015
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTHO	ONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	An incident report of evening cares, nursilicensed practical in R55's left inner glut noted the cause wa (RN)-J assessed th 4/20/15. The bruise centimeters (cm) X located on the inner covering an area newas unaware of how director of nursing (ED) were notified of investigation initiated. During interview on stated she was not two days later, "we origin." The DON, ED and Stated 10/200 reporters will immediate administrator/executacility shall report in Entry Point. The pounexplained injuries neglect, abuse in parepeated or malicio language toward a streatment of a vulne administrator of a vulne attreatment of a v	ng, locomotion and toileting. lated 4/20/15, indicated during sing assistant (NA)-I alerted urse (LPN)-F about a bruise to eal area on 4/18/15. LPN-F is unknown. Registered nurse e bruise with RN-F on was noted to be 11 6 cm, dark purple in color and raspect of the left buttock ear the coccyx and anus. R55 with the bruise occurred. The (DON) and executive director of incident on 4/20/15 and an ed. 10/29/15, at 1:28 p.m. DON sure why they were notified report injuries of unknown	21980	DETIOIENCT)		

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	
		00522	B. WING		10/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	IONY HEALTH CENTE	-R	S ROAD NO DNY, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 56	21980			
	The administrator of need to immediatel to the designated signated	THOD OF CORRECTION: could in-service all staff on the yreporting suspected abuse tate agency/common entry				
22000		6.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			12/3/15
	facility, except hom personal care attent establish and enfor prevention plan. The assessment of the environment, and it factors which may early and a statement of to minimize the risk comply with any rul promulgated by the (b) Each facility, agency and person providers, shall dever prevention plan for residing there or reacting there or reacting there or reacting the plan shall contrassessment of: (1) abuse by other individual vulnerable adults; (other vulnerable ad specific measures trisk of abuse to that	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. Including a home health care all care attendant services relop an individual abuse each vulnerable adult ceiving services from them. In an individualized the person's susceptibility to viduals, including other (2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the to person and other vulnerable poses of this paragraph, the				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1 ` ´			B) DATE SURVEY COMPLETED		
			A. BUILDING:			`		
		00522	B. WING			, 9/2015		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ST ANTH	ST ANTHONY HEALTH CENTER 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	(X5) COMPLETE DATE			
22000	and personal care a knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Und of a vulnerable adu misconduct or phys such information fro authority or through another facility, and	except home health agencies attendant services providers, erable adult has committed a act of physical aggression individual abuse prevention at the vulnerable adult might exted to pose to visitors to the outside the facility, if the this section, a facility knows lt's history of criminal sical aggression if it receives om a law enforcement a medical record prepared by other health care provider, or grassessments of the	22000					
	by: Based on interview facility failed to imple policy for immediate and State Agency (violation regardings of 4 residents (R55 reviewed. Findings include: The facility Vulneral policy dated 10/06, will immediately regardinistrator/executacility shall report in	and document review, the lement the abuse prevention ely notifying the administrator SA) regarding an alleged truises of unknown origin for 1 whose incidents were ble Adult Abuse Prohibition indicated mandated reporters port to the utive director and that the mmediately to the Common licy further outlined that		Corrected				

Minnesota Department of Health

STATE FORM 6899 MVY611 If continuation sheet 58 of 60

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00522	B. WING		10/2) 9/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST ANTI	ST ANTHONY HEALTH CENTER 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE		
22000	unexplained injuries neglect, abuse in parepeated or malicio language toward a treatment of a vulne considered threater shall be reported. R55 had a diagnose muscle weakness, listed on the Face Sannual Minimum Daindicated R55 had and required extensibed mobility, dressi An incident report of evening cares, nursilicensed practical in R55's left inner glut noted the cause wa (RN)-J assessed the 4/20/15. The bruise centimeters (cm) X located on the inner covering an area newas unaware of hordirector of nursing ((ED) notified of incinitiated. During interview on stated she was not two days later, "we origin."	s, therapeutic error with injury, art defined as "the use of us oral, written or gestured vulnerable adult or the erable adult which could be ning" and financial exploitation es that included general dementia and depression sheet dated 4/21/15. The ata Set dated 5/15/15, severe cognitive impairment sive assistance of two staff for ng, locomotion and toileting. Isted 4/20/15, indicated during sing assistant (NA)-I alerted urse (LPN)-F about a bruise to eal area on 4/18/15. LPN-F as unknown. Registered nurse e bruise with RN-F on a was noted to be 11 6 cm, dark purple in color and a spect of the left buttock ear the coccyx and anus. R55 when the bruise occurred. The (DON) and exucutive director dent on 4/20/15. Investigation 10/29/15, at 1:28 p.m. DON sure why they were notified report injuries of unknown SA all were notified on fter the bruise of unknown	22000				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST ANTHONY HEALTH CENTER STANTHONY, MN 55421 C	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 22000 Continued From page 59 Suggested Method of Correction: The director of nursing (DON) could work with the administrator to ensure the abuse prohibiton policy was implemented as written to meet Federal requriements, and then could educate staff. The DON or designee could also perform audits to ensure reports to the SA occurred in the requried timeframes. Time Period for Correction: Twenty-one (21)			00522	B. WING					
STANTHONY HEALTH CENTER STANTHONY, MN 55421	NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 22000 Continued From page 59 Suggested Method of Correction: The director of nursing (DON) could work with the administrator to ensure the abuse prohibiton policy was implemented as written to meet Federal requriements, and then could educate staff. The DON or designee could also perform audits to ensure reports to the SA occurred in the requried timeframes. Time Period for Correction: Twenty-one (21)	I SLANIHONY HEALIH CENIER								
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	22000	Suggested Method nursing (DON) coul to ensure the abuse implemented as wri requriements, and t DON or designee c ensure reports to the timeframes.	of Correction: The director of d work with the administrator e prohibiton policy was itten to meet Federal then could educate staff. The ould also perform audits to be SA occurred in the requried	22000	BEI KIENOTY				