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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MVY6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00522

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245267**

2.STATE VENDOR OR MEDICAID NO.
(L2) **369742800**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/22/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **150** (L18)

13.Total Certified Beds **150** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jonathan Hill, HFE NE II 1/5/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/5/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

Electronically delivered
January 5, 2016

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

RE: Project Number S5267027

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

Kamala Fiske-Downing, Program Specialist
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245267	A. Building B. Wing	12/22/2015

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **12/03/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/03/2015**
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/03/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **12/03/2015**
ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0372** Reg. # **483.35(i)(3)** LSC	Correction Completed **12/03/2015**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/03/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/03/2015**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/kfd	1/5/2016	25480	12/22/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/29/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245267	A. Building B. Wing 01 - MAIN BUILDING 01	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0046	12/03/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/kfd	1/5/2016	27200	12/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
10/29/2015	YES NO

MDH
Minnesota Department of Health

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

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

AH Form Approved
1/5/2016

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00522	A. Building B. Wing	12/22/2015

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 12/03/2015	ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 12/03/2015	ID Prefix 20910 Reg. # MN Rule 4658.0525 Subp. 5 LSC	Correction Completed 12/03/2015
ID Prefix 20930 Reg. # MN Rule 4658.0525 Subp. 7 LSC	Correction Completed 12/03/2015	ID Prefix 21015 Reg. # MN Rule 4658.0610 Subp. 1 LSC	Correction Completed 12/03/2015	ID Prefix 21390 Reg. # MN Rule 4658.0800 Subp. 4 LSC	Correction Completed 12/03/2015
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Sul LSC	Correction Completed 12/03/2015	ID Prefix 21525 Reg. # MN Rule 4658.1305 A.B.C LSC	Correction Completed 12/03/2015	ID Prefix 21545 Reg. # MN Rule 4658.1320 A.B.C LSC	Correction Completed 12/03/2015
ID Prefix 21610 Reg. # MN Rule 4658.1340 Subp. 1 LSC	Correction Completed 12/03/2015	ID Prefix 21735 Reg. # MN Rule 4658.1420 LSC	Correction Completed 12/03/2015	ID Prefix 21805 Reg. # MN St. Statute 144.651 Sul LSC	Correction Completed 12/03/2015
ID Prefix 21810 Reg. # MN St. Statute 144.651 Sul LSC	Correction Completed 12/03/2015	ID Prefix 21980 Reg. # MN St. Statute 626.557 Sul LSC	Correction Completed 12/03/2015	ID Prefix 22000 Reg. # MN St. Statute 626.557 Su LSC	Correction Completed 12/03/2015

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/kfd	1/5/2016	25480	12/22/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/29/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: MVY6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00522

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/29/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **150** (L18)

13.Total Certified Beds **150** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Becky Wong., HFE NE II 11/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
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 Fiske-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

MDH
Minnesota
Department
of Health

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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.	F 000		
F 225 SS=D	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. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification	F 225		12/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/27/2015

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F 225	Continued From page 1 agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bruises of unknown origin were immediately reported to the administrator and State agency (SA) for 1 of 4 residents (R55) reviewed for incidents. Findings include: R55 had a diagnoses that included general muscle weakness, dementia and depression listed on the Face Sheet dated 4/21/15. The annual Minimum Data Set (MDS) dated 5/15/15, indicated R55 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, dressing, locomotion and toileting. An incident report dated 4/20/15, indicated during evening cares, nursing assistant (NA)-I alerted	F 225	St. Anthony Health Center (SAHC) makes its best effort to operate in full compliance with state and federal law. Nothing included in this plan of correction is an admission otherwise. SAHC has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that SAHC may contest the merits and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. Please accept this plan of correction as SAHC's	

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F 225	Continued From page 2 licensed practical nurse (LPN)-F about a bruise to R55's left inner gluteal area on 4/18/15. LPN-F noted the cause was unknown. Registered nurse (RN)-J assessed the bruise with RN-F on 4/20/15. The bruise was noted to be 11 centimeters (cm) X 6 cm, dark purple in color and located on the inner aspect of the left buttock covering an area near the coccyx and anus. R55 was unaware of how the bruise occurred. The director of nursing (DON) and executive director (ED) were notified of incident on 4/20/15 and an investigation initiated. During interview on 10/29/15, at 1:28 p.m. DON stated she was not sure why they were notified two days later, "we report injuries of unknown origin." The DON, ED and SA all were notified on 4/20/15, two days after the bruise of unknown origin was discovered. The facility Vulnerable Adult Abuse Prohibition policy dated 10/2006, indicated that mandated reporters will immediately report to the administrator/executive director and that the facility shall report immediately to the Common Entry Point. The policy further outlined that unexplained injuries, therapeutic error with injury, neglect, abuse in part defined as "the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which could be considered threatening" and financial exploitation shall be reported.	F 225	allegation of substantial compliance. 1.Resident R55 expired. 2.The facility Vulnerable Adult Abuse Prevention policy and procedure has been reviewed. 3.The Administrator and DON attended VAA education at Care Providers on 11/17/15. 4.Staff have been re-educated on the facility Vulnerable Adult Abuse Prevention policy and program. 5.The IDT will review each incident to determine reportability and appropriate preventative measures are put in place. 6.The facility QA&A committee will review all incidents monthly. 7.See also F226. 8.The Executive Director remains responsible for compliance with this requirement, to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		12/3/15

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F 226	Continued From page 3 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prevention policy for immediately notifying the administrator and State Agency (SA) regarding an alleged violation regardingbruises of unknown origin for 1 of 4 residents (R55) whose incidents were reviewed. Findings include: The facility Vulnerable Adult Abuse Prohibition policy dated 10/06, indicated mandated reporters will immediately report to the administrator/executive director and that the facility shall report immediately to the Common Entry Point. The policy further outlined that unexplained injuries, therapeutic error with injury, neglect, abuse in part defined as "the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which could be considered threatening" and financial exploitation shall be reported. R55 had a diagnoses that included general muscle weakness, dementia and depression listed on the Face Sheet dated 4/21/15. The annual Minimum Data Set dated 5/15/15, indicated R55 had severe cognitive impairment	F 226	1.Resident R55 expired. 2.The facility Vulnerable Adult Abuse Prevention policy and procedure has been reviewed. 3.The Administrator and DON attended VAA education at Care Providers on 11/17/15. 4.Staff have been re-educated on the facility Vulnerable Adult Abuse Prevention policy and program. 5.The IDT will review each incident to determine reportability and appropriate preventative measures are put in place. 6.The facility QA&A committee will review all incidents monthly. 7.See also F225. 8.The Executive Director remains responsible for compliance with this requirement, to ensure that the abuse prevention policy is implemented.	

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F 226	Continued From page 4 and required extensive assistance of two staff for bed mobility, dressing, locomotion and toileting. An incident report dated 4/20/15, indicated during evening cares, nursing assistant (NA)-I alerted licensed practical nurse (LPN)-F about a bruise to R55's left inner gluteal area on 4/18/15. LPN-F noted the cause was unknown. Registered nurse (RN)-J assessed the bruise with RN-F on 4/20/15. The bruise was noted to be 11 centimeters (cm) X 6 cm, dark purple in color and located on the inner aspect of the left buttock covering an area near the coccyx and anus. R55 was unaware of how the bruise occurred. The director of nursing (DON) and exucutive director (ED) notified of incident on 4/20/15. Investigation initiated. During interview on 10/29/15, at 1:28 p.m. DON stated she was not sure why they were notified two days later, "we report injuries of unknown origin." The DON, ED and SA all were notified on 4/20/15, two days after the bruise of unknown origin was discovered.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 241	1.Resident R289 has been discharged	12/3/15

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F 241	Continued From page 5 review ,the facility failed to ensure 4 of 5 residents (R43, R77, R289, R291) cares were provided in a dignified manner. Findings include: R43's diagnosis included anxiety, glaucoma, cataract, mild cognitive impairment, Osteoporosis, muscle weakness, major depression and osteoarthritis obtained from form the Face Sheet dated 10/29/15. 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. Privacy curtain was not pulled around the bed. -At 7:35 a.m. NA-E entered the room indicated R43 was in her group and was going to get her ready for the day. -At 7:36 a.m. to 7:39 a.m. both NA's were observed remove R43's hospital gown and	F 241	from the facility. 2.The identified residents R291, R43, and R77 care plans and NAR assignment sheets have been reviewed and updated as needed. 3.Staff will be re-trained on providing for resident dignity, using specific survey examples cited in the 2567. 4.Facility leadership will complete dignity/ resident care audits 2x/week until the next QA&A meeting 12/15/15. 5.The Director of Nursing will review the completed audits and bring any identified concerns to the facility QA&A committee for review and further recommendations. 6.The Executive Director remains responsible for compliance with this requirement to ensure residents are cared for in a dignified manner	

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F 241	Continued From page 6 proceeded to wipe her upper body including the back then pat dried the area did not cover R43. NA-E then applied socks and pants half way. Still R43's breast exposed. -At 7:40 a.m. NA-D cued R43 to open her legs then completed pericare in the front. Then both NA's cued R43 to roll as NA-D cleansed her bottom. NA-D removed the soiled gloves and never washed her hands, went over to the dresser by the wall across from R43's bed and indicated the glove box was empty, then reached over to her right side scrubs pocket got one glove out but never applied it. NA-D then indicated to NA-E she was going outside the room to get R43's wheelchair. NA-D left the room went outside the hallway left the door wide open as NA-E was standing at resident bed applying the incontinent pad with resident breast still exposed and privacy curtain not pulled. Surveyor followed out and was able to see R43's entire body when standing in the hallway looking into the room. NA-D then wheeled R43's wheelchair into the room shut the door. Both NAs were observed adjust R43's pants then cued R43 they were going to assist her to get seated at the edge of bed before 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. -At 7:44 a.m. with both NAs standing to R43's 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	F 241		

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F 241	Continued From page 7 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 of the weather and being cold. Staff are also supposed to pull the privacy curtain with cares all the time that is my expectation." On 10/29/15, at 3:00 p.m. the director of nursing (DON) stated she would have expected staff to provide for privacy during cares. Acknowledged was a dignity concern. Activities of daily living (ADL's) Care Area Assessment (CAA) dated 2/5/15, indicated R43 required extensive assistance with dressing	F 241		

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F 241	Continued From page 8 bathing and personal hygiene. R77's diagnoses included depression, schizophrenia and use of gastric tube (GT) (tube feeding (TF) obtained from the quarterly Minimum Data Set (MDS) dated 8/11/15. On 10/29/15, at 7:01 to 7:10 a.m. LPN-A was observed set R77's medications. -At 7:11 a.m. both LPN-A and surveyor went to room to observe medication administration via gastrostomy tube (GT). LPN-A stated to R77 she was going to administer morning medications. Upon entering room, R77 was lying on her back, eye closed and the head of bed was at approximately 20 degrees. LPN-A set the medication on the bedside pull table went to the bathroom, obtained water in a cylinder (measuring device) and applied gloves. LPN-A then disconnected the tube feeding cleansed the end with alcohol hang it up on the pool. Stated to resident she was going to listen to her stomach then after administered medications via GT. During the entire observation time door was wide open and the privacy curtain was pulled to the length of the roommate's bed. -At 7:16 a.m. R77's roommate got out of bed came around and picked into R77's side stood there briefly then went over to the dresser and walked past R77's area/space as she went into the shared bathroom. LPN-A still administering medications. On 10/29/15, at 12:07 p.m. LPN-A acknowledged she had neither closed the door nor pulled the privacy curtain during the procedure. LPN-A stated it was supposed to have been done to	F 241		

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F 241	Continued From page 9 provide R77 privacy. On 10/29/15, at 2:59 p.m. the director of nursing stated, "If the resident was exposed she would have expected the nurse to have shut the door and pulled the privacy curtain." On 10/29/15, at 1:34 p.m. a dignity policy was requested but the director of nursing stated "We do not have a dignity policy. We follow the resident rights." R289's admission MDS dated 10/23/15, indicated R289 was severely cognitively impaired and required assistance with all ADLs. R289's MDS indicated R289 was frequently incontinent of bowel and bladder. R289's MDS included diagnosis of dementia and depression. Continuous observation on 10/28/15, from 7:06 a.m. until 10:47 a.m. -7:06 a.m. Resident was sleeping in room. -7:38 a.m. Nursing assistant (NA)-A entered R289's room and stated it was time to get up. -7:39 a.m. NA-A left to get help. -7:40 a.m. NA-A returned to R289's room. -7:41 a.m. NA-C knocked on the door and entered the room without waiting for acknowledgement. -7:42 a.m. Explained what they were going to do and encouraged R289 to get dressed. R289 said "I am afraid." NA-C used a soothing voice to explain staff were here to help R289 get dressed and encouraged R289 to roll over so NA-A could wash R289's bottom. R289 would not turn over and just held NA-C's hand. -7:51 a.m. NA-A and NA-C told R289 they would tell the nurse R289 did not want to get up. NA-A instructed R289 to use call light to call for	F 241		

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F 241	Continued From page 10	F 241		

assistance when ready to get up and left room. R289 lying in bed covered with a sheet. R289's face appeared distressed, eyes narrowed, lips trembling. clutching top of sheet. R289 stated "I am so frightened." Resident had on red anti slip socks and black slacks that were partially pulled up legs. Incontinence pad was open under R289's buttocks.
-8:09 a.m. Resident lying on bed staring at ceiling hand clenched on sheets.
-8:22 a.m. NA-A and NA-B entered R289's room without knocking. NA-A and NA-B informed R289 that they were here to get R289 up for breakfast. NA-A stated to NA-B, "The nurse said she will get her up." NA-B handed R289 a wash cloth and encouraged R289 to wash face and praised R289 for doing a good job. R289 refused to have underarms washed. NA-A said over R289's head, "see [R289] doesn't want cares."
-8:34 a.m. RN-D knocked and entered without waiting for a response. RN-D encouraged R289 to get up for breakfast. R289 said, "I feel so lost." NA-A rolled his head and eyes towards the ceiling.
-8:51 a.m. RN-D Left the room. NA-A stated "This is where the fight is going to happen." After R289 was up and dressed the resident went to breakfast.

During interview on 10/28/15, at 9:28 a.m. RN-D stated, "I thought I knocked but I am so busy today."

During interview on 10/28/15, at 10:32 a.m. NA-A stated, "I am so nervous I must have forgotten to knock."

During interview on 10/29/15, at 2:35 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 241	Continued From page 11 DON stated she expected staff to knock and wait for a response before entering a room. The DON stated she would not expect staff to roll head at resident comments. R291's Face Sheet printed 10/29/15, indicated R291 diagnoses included aphasia (difficulty communicating) and diabetes. Physician Order Sheet printed 10/29/15, instructed staff to check R291's blood sugars four times a day. During a blood sugar observation on 10/29/15, at 4:30 p.m. LPN-B entered R291's room and explained the procedure. LPN-B put the glucometer (a machine for checking blood sugars) bucket down on over the bed table without a barrier between the bucket and over the bed table. LPN-B washed hands and turned the water off. LPN-B cleaned glucometer with a PDI wipe and allowed to dry for two minutes. LPN-B put on clean gloves, wiped R291's finger with an alcohol wipe. LPN-B pricked R291's finger, wiped off the first drop of blood and took a drop of blood on test strip. LPN-B put the glucometer down on barrier. Cleaned glucometer with PDI wipes and let dry. LPN-B wrapped glucometer in paper towel and put it in the bucket. LPN-B removed gloves and washed hands, turning off facet with bare hands. During the entire procedure the door to the room was open and privacy curtain was not pulled to afford R291 privacy. On 10/29/15, at 4:43 p.m. R291 said, "I wish he had shut the door."	F 241		

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 241	Continued From page 12 During interview on 10/29/15, at 4:45 p.m. LPN-B acknowledged, "I did not shut the door while checking the blood sugar. I should have." The facility's Our Platinum Service Standards form undated directed staff be considerate and treat residents with dignity and respect.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 3 residents (R77) reviewed for incontinence and who were capable of using the call light. Findings include: On 10/27/15, at 9:58 a.m. during R77 room observation the call light was observed on floor on the other side of bed not accessible to R77. Both registered nurse (RN)-K and RN-L verified the call light was not at reach. -At 10:00 a.m. when asked if she was able to use the call light R77 shook her head and when asked to demonstrate R77 was not able to put the call light on as the cord was wrapped up with	F 246	1.Resident R77 care plans and NAR assignment sheets have been reviewed and updated as needed. 2.Staff will be re-trained on providing for resident accommodation of needs, using specific survey examples cited in the 2567. 3.Facility leadership will complete call light placement audits 2x/week until the next QA&A meeting 12/15/15. 4.The Director of Nursing will review the completed audits and bring any identified concerns to the facility QA&A committee for review and further recommendations. 5.The Executive Director remains responsible for compliance with this requirement to ensure residents are	12/3/15

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 246	Continued From page 13 other strings which made it hard for her to use her call light. On 10/29/15, at 2:59 p.m. the director of nursing stated the call light was supposed to be at reach for all residents who were capable of using it. R77's diagnoses included abnormality of gait, general muscle weakness, major depression and mild cognitive impairment obtained from the care plan report dated 11/6/15. R77's care plan for falls dated 11/6/15, identified R77 at risk for fall as evidenced by history of fall with neck injury. The care plan directed staff to keep "Call light within reach [left] (L) side bed enabler bar." In addition the care plan indicated "Resident has also been reminded to use her call light for assistance with any needs and she verbalized understanding to the counsel." On 10/29/15, at 3:00 p.m. the call light policy was requested but was not provided.	F 246	provided services with reasonable accommodation of individual needs.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		12/3/15

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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F 280	Continued From page 14 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the plan of care was revised for 1 of 1 resident (R77) which included keeping the head of bed elevated to prevent aspiration during continuous tube feedings. Findings include: On 10/27/15, at 9:58 a.m. R77 was observed to be in bed, with the head of bed (HOB) head of bed raised only about 10 degrees while a tube feeding (TF) was being infused via gastric tube (GT). On 10/27/15, at 11:30 a.m., R77 was again observed to be lying in bed without the HOB elevated more than 10 degrees. A tube feeding was observed to be running at 70 milliliters (ml's) per hour via GT. On 10/28/15, at 7:45 a.m. R77 appeared asleep in bed. R77 was lying on back, but was crooked in the bed. R77's head was toward wall and left foot partially off bed and the lower extremities were edematous. The HOB approximately 10	F 280	1.Resident R77 care plans have been reviewed and revised with enteral tube feeding information as needed. 2.The care plans of all other resident with tube feedings have been reviewed and revised as needed. 3.The Nursing Leadership team received education on auditing care plans on 11/19/15. 4.Nursing staff will be educated on the completion and updating of care plans. 5.An assessment and care plan audit will be completed by nursing leadership weekly until the next QA&A 12/15/15. 6.The facility QA&A committee will review completed audit results and make further recommendations. 7.See also F322. 8.The Director of Nursing remains responsible for compliance with this requirement, to ensure comprehensive care plans are developed to meet resident needs.	

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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F 280	Continued From page 15 degrees of elevation, with the TF attached and running at 70 ml's/hr. -At 9:30 a.m. staff were prompted to observe R77, when staff entered the room, registered nurse (RN)-G immediately elevated the HOB, and stated when asked "the HOB should be elevated when the tube feeding was running, should be at 45 degrees." On 10/29/15, from 7:01 to 7:04 a.m., during medication administration with licensed practical nurse (LPN)-A, the HOB was observed at 20 degrees upon entering the room and during the entire time LPN-A was administering medication. LPN-A never elevated the HOB during the procedure, R77 appeared to be asleep with eyes closed during the entire procedure. R77's admission record indicated the resident had been admitted to the facility on 3/17/14, with diagnoses of dysphagia of the oropharyngeal phase, fracture of cervical vertebra, generalized weakness, use of gastric tube (GT) (gastric tube feeding (TF) directly to the stomach by a tube inserted through the skin), pulmonary embolus (blood clot affecting lungs/lung function) and respiratory failure. R77's Care Plan dated 3/17/14, to present indicated: Problem areas: "Nutrition Need, (eating, aspiration risk, etc.) as evidenced by tube feeding, and Need for artificial nutrition related to seizures and dysphagia as evidenced by need for enteral feeding through 'GT' tube." Goals included: "Resident to tolerate tube feeding (goal date of 1/27/16) " Interventions included: "Resident monitored at meals and when taking	F 280		

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 280	Continued From page 16	F 280		

fluids; Appropriate referrals will be made; Adjustments will be made in the care of the resident to decrease the risk of aspiration; Notify MD [medical doctor] and obtain appropriate orders (thick liquids, etc.) Resident to be observed by staff at meals and when taking fluids; NPO [nothing by mouth] last updated 5/17/15; oral care every 2 hours; GT tube feeding- continue to monitor intake, weights and labs per facility protocol and intervene when appropriate; SLP [Speech Language Pathology] swallow clarification- Ok for nectar thick liquids via cup sip if sitting upright and supervised. Use small sips and chin tuck; Provide TF and H20 (water) as ordered." Although the care plan identified the tube feeding use, there were no interventions to direct staff related to the position of the bed during the GT feeding such as, how high the HOB should be to prevent potential aspiration, nor was there any indication on the care plan that the resident refused any treatment such as having the HOB elevated, due to comfort.

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 running at 70 ml's per hour. At 9:47 the LPN-A was brought into the room to observe R77, and verified the HOB should not be flat, and LPN-A elevated the HOB to 30 degrees. LPN-A listened the resident lungs and stated the "lungs were clear."
- At 11:11 a.m. RN-B stated the HOB should always be between 45 to 90 degrees to prevent risk of aspiration.
- At 2:17 pm the director of nursing (DON) stated the HOB should be elevated as much as tolerated 45 degrees, the DON verified best

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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F 280	Continued From page 17 practice would be to have the HOB elevated at a minimum 30 degrees to prevent aspiration. The facility policy for Tube Feeding-Enteral dated 7/23/13, directed staff: 4. "Resident's with continuous enteral feeding must have their HOB 30 to 45 degrees at all times." 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 30º - 45º to prevent aspiration and pneumonia."	F 280		
F 282 SS=D	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 by: Based on observation, interview, and document review, facility failed to check and change a resident in accordance with their plan of care, for 1 of 3 (R289) residents observed for activities of daily living. Findings include: The Care Plan Report dated 10/28/15, instructed R289 had an alteration in bowel and bladder function and instructed staff to toilet the resident upon rising, before and after meals, with night	F 282	1.Resident R289 no longer resides in the facility. 2.Other residents will have their Toileting care plans updated with each quarterly, annual, or significant change of condition MDS. 3.Staff will be in-serviced on following care plan interventions/NAR assignment sheets and toileting schedules using specific survey findings as an example. 4.Nursing leadership will complete toileting audits 2x/week until the next	12/3/15

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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F 282	Continued From page 18 rounds and as needed. R289 was to be checked and change every (Q) two hours (hrs). The nursing assistant (NA) undated assignment sheet indicated R289 incontinent of bladder. Resident Care Summary Plan of Care (POC) undated instructed staff "Check and change Q 2hr" copy requested but not received. Continuous observation on 10/28/15, from 7:06 a.m. until 10:47 a.m. noted the following: -7:06 a.m. Resident was sleeping in room. -7:42 a.m. Nursing assistant (NA)-A explained to R289 that they were going to help R289 get up and get dressed. NA-A opened incontinent brief and attempted to wash R289 up. -7:51 a.m. NA-A and NA-C told R289 that they would tell the nurse that R289 did not want to get up. NA-A instructed R289 to use call light to call for assistance when ready to get up and left room. R289 lying in bed covered with a sheet. The resident had on red anti slip socks and black slacks that were partially pulled up legs. Incontinent pad was open under R289's buttocks. -8:00 a.m. registered nurse (RN)-D spoke with R289. R289 agreed to get up for breakfast. -8:22 a.m. NA-A and NA-B informed R289 that they were here to get R289 up for breakfast. - 8:40 a.m. NA-A and NA-B put a dry incontinence product on R289. -8:55 a.m. R289 on way to dining room. -9:21 a.m. R289 brought to sitting area next to nursing station. -10:28 a.m. Activities-A took resident to church. -10:42 a.m. Resident at church at Chandler Place. -10:47 a.m. Church service started. -11:34 a.m. Activities staff-A informed surveyor	F 282	QA&A meeting on 12/15/15. 5.The facility QA&A committee will review completed audit results and make further recommendations. 6.The Director of Nursing remains responsible for compliance with this requirement, to ensure that residents receive the appropriate treatment and services to improve/maintain ADLS.	

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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F 282	Continued From page 19 R289 was back on unit. R289 did not stop any where on way back. R289 did not go to the bathroom while at church. R289 was seated next to desk. -11:50 a.m. R289 taken to room and incontinent pad checked. R289 was dry. During interview on 10/28/15, at 10:45 a.m. Activities staff-A stated, "I let the staff know before I took R289 off the unit." During interview on 10/28/15, at 11:41 a.m. NA-A stated, "After [R289] ate [R289] went to therapy and now she is back, we are to toilet R298 after breakfast. I have not toileted R289 yet." During interview on 10/28/15, at 12:25 p.m. RN-C stated I would expect them to attempt toileting, check and change every two hours. I would expect the staff to follow the plan of care. RN-C verified the correct toileting plan was to check and change R289 every two hours. During interview on 10/29/15, at 2:35 p.m. director of nurses (DON) verified expected staff to follow check and change every two hours if on plan of care.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent	F 315		12/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 20 urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and provide appropriate care and services for 1 of 2 patients (R24) reviewed who had an indwelling Foley catheter (a thin, sterile tube inserted into the bladder to drain urine which can be left in place for a period of time). Findings include: During observation on 10/28/15, at 3:43 p.m. R24 was observed to have a Foley catheter tube and drainage bag containing clear yellow urine. At that time, R24 stated he'd had the Foley catheter in place for six months or better and had recently had to go to the hospital to have it changed. R24's current care plan printed on 10/28/15, indicated R24 had problems including: "alteration in urinary elimination related to diabetic as evidenced by Foley catheter in use and history of antibiotic medication for a diagnosis of UTI [urinary tract infection]" and "Indwelling catheter for diagnosis of urinary retention with obstruction secondary to renal failure. A hospital readmission Clinical Note dated 5/5/15, indicated R24 had been readmitted with an indwelling Foley catheter. A note from 5/8/15, indicated staff had been going to remove the catheter, but R24 had "requested to have the Foley removed tomorrow morning (5/9/15)." The	F 315	1.Resident R24 expired 11/13/15. 2.Other residents with catheters have had their Bladder assessment, Physician orders, and care plans reviewed and revised as needed. 3.The Catheter care policy has been reviewed and remains appropriate. 4.Staff will be in-serviced on the catheter care policy. 5.Nursing leadership will complete catheter audits 2x/week until the next QA&A committee meeting 12/15/15. 6.The facility QA&A committee will review completed audit results and make further recommendations. 7.The Director of Nursing remains responsible for compliance with this requirement, to ensure that residents receive the appropriate treatment and services to prevent urinary tract infections.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 315	Continued From page 21 Clinical Notes indicated the catheter remained in place until 9/29/15, when a nurse removed and attempted (unsuccessfully) to reinsert it. The Clinical Notes dated 9/29/15, indicated R24 was ordered to have indwelling catheter changed during morning shift due to risk for infection. "Writer tried two times to insert new Foley using a 16 F [French, a unit of measurement] catheter but was unsuccessful. NP [nurse practitioner] then ordered a Coude' tip Foley catheter" [a bent tip that maneuvers around obstructions leading to the bladder], which was the type of catheter that had originally been inserted in the hospital in May. "Writer, with the assistance of another floor nurse manager tried the procedure, yet unable to complete task. NP gave order to send resident to ER [emergency room] for further evaluation if unsuccessful. [R24] informed with above order but declined at this time. Resident stated 'I have been voiding now'. Nursing monitoring [R24's] output throughout shift for possible retention and intervene as appropriate." The Clinical Notes dated 9/29/15, R24 was ordered to have indwelling catheter changed during morning shift due to risk for infection. "Writer tried two times to insert new Foley using a 16 F catheter but was unsuccessful. NP then ordered a Coude' tip Foley catheter [a bent tip that maneuvers around obstructions leading to the bladder] which was originally inserted from the hospital. Writer, with the assistance of another floor nurse manager tried the procedure, yet unable to complete task. NP gave order to send resident to ER [emergency room] for further evaluation if unsuccessful. [R24] informed with above order but declined at this time. Resident	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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F 315	Continued From page 22	F 315		

stated 'I have been voiding now'. Nursing monitoring [R24's] output throughout shift for possible retention and intervene as appropriate."

On 9/30/15, the Clinical Notes indicated R24 "was monitored all night, voided 350 cc [cubic centimeters] yellow color, no signs/symptoms of infection." Another Clinical Note from 9/30/15 included: "without Foley catheter. Had 750 cc output, 0 cc bladder scan PVR [post void residual]. R24 asking for tomorrow's appointment time. Daily schedule with no appointment information, was informed will update tomorrow." Clinical notes from 10/1/15, indicated: "today's hospital appointment was to put catheter in, told no appointment at this time, writer to call NP to update regarding output and bladder scan result from yesterday. [R24] saying 'I don't care whatever she said I need to and I want to go to put catheter in right now, you hear me', NP updated on output and bladder scan yesterday, okay to send to ER to put catheter in per [R24] request." The notes indicated R24 was sent to the hospital 10/1/15, at 10:15 a.m. for catheter insertion.

The hospital Discharge Summary Note indicated R24 had been sent to the hospital 10/1/15 for an indwelling catheter replacement and had urine culture completed which was positive for a UTI, so antibiotics had been initiated for R24.

A Clinical Note entry dated 10/2/15, at 3:55 p.m. indicated the resident had arrived back at the facility: "Foley intact, output 800 cc, urine yellow, was started on Cipro 500 milligrams [mg] x 7 days for UTI." The notes also indicated R24 had returned with orders related to the Foley

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 23	F 315		

including; to be seen by urology monthly for catheter replacement, and for nursing to continue to monitor for signs/symptoms of infection and adjust per resident's needs.

Further review of R24's medical record lacked any indication that the catheter had been changed from 5/5/15 to 9/29/15. In addition, physician and nurse practitioner notes from 5/7/15 through 10/1/15, were reviewed. Their notes did not address the indwelling catheter prior to his hospitalization for catheter replacement and infection. In addition, the Physician Order Sheets prior to 10/2/15, lacked any direction for staff to provide care and treatment of the indwelling catheter such as; size of catheter, balloon size, what signs and symptoms to monitor for, and when to replace the indwelling catheter.

The facility's form, Bowel and Bladder Evaluation dated 5/10/15, indicated R24 was continent of bladder with Foley catheter placed. This evaluation revealed R24 was at risk for incontinence due to being immobile, and was cognitively impaired - made poor decisions, and was dependent upon two staff for transfers. The evaluation did not address diagnoses which could have affected continence, i.e.., kidney calculi and CHF (congestive heart failure) which had been present at the time of admission per the 5/15 hospital discharge documents. The evaluation also did not include a review of medications that could affect kidney dysfunction such as: use of a diuretic (Bumex), antidepressant use (Effexor), antianxiety use (hydroxyzine), and use of narcotic pain medication (Oxycontin and oxycodone PRN [as

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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F 315	Continued From page 24	F 315		

needed]). Each of these medications were included on the May 2015 Physician Order Sheet. Although Bowel and Bladder Evaluation indicated a trial period of urinary retraining had been done with no improvement, there was no documentation on the Evaluation, nor in the Clinical notes to indicate when such retraining had been attempted prior to the removal of the catheter 9/29/15. On the Evaluation form there was a section identified as: Evaluation For Residents With Indwelling Catheters. This section included indications for a Foley such as: identifying need for exact measurement of urine output, diagnoses such as unstageable pressure ulcers, terminal illness, severe impairment and movement with intractable pain, or untreatable urethral blockage causing urinary retention (documented by PVR of over 200 milliliters (ml) and staff unable to perform intermittent catheterization (three failed attempts). This section of the Bowel and Bladder Evaluation form indicated residents with indwelling catheters should meet at least one of the identified conditions, however R24 did not meet any. Finally, the Evaluation form failed to indicate any removal plan, or risks of complications resulting from the use of a catheter such as infection, blockage, bypassing urine, pain, discomfort, bleeding or expulsion.

A quarterly Minimum Data Set (MDS) dated 7/10/15, indicated R24 had diagnoses of diabetes, renal insufficiency and neurogenic bladder with an indwelling Foley catheter. The MDS indicated R24 was cognitively intact.

On 10/2/15, a new Bowel and Bladder Evaluation form was completed at 11:16 a.m.. The

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 315	Continued From page 25 Evaluation again indicated R24 was continent of bladder with Foley catheter placed. The evaluation revealed the same outcome as the prior form completed 5/5/15, with this exception: R24 was at risk for incontinence due to being immobile, and was cognitively impaired - made poor decisions, and was dependent upon two staff for transfers. In addition, the form indicated R24 had antianxiety (hydroxyzine and lorazepam), and a narcotic used for pain control (Oxycontin, morphine sulfate, and oxycodone PRN) as indicated per the October 2015 Physician Order Sheet. In addition, the Physician Order Sheet post 10/2/15 directed staff to have R24 seen by the urologist every month for a catheter change due to urinary retention. This Evaluation form remained incomplete regarding R24 diagnoses and still not include a removal plan or risks/complications resulting from the use of a catheter such as infection, blockage, bypassing urine, pain, discomfort, bleeding or expulsion. On 10/29/15, at 9:03 a.m. registered nurse (RN)-F was interviewed. RN-F confirmed R24's catheter had been removed on 9/29/15. RN-F further verified the nurse had not been able to reinsert a catheter so they'd initiated monitoring output, and had updated the MD. RN-F stated R24 had been sent to the hospital for Foley replacement on 10/1/15, and had been admitted. She further verified that when R24 came back to the facility, he had new orders for monthly catheter replacement by urology. RN-F stated there had not previously been orders for monthly catheter change including size or type of catheter.	F 315		

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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F 315	Continued From page 26 On 10/29/15, at 2:44 p.m. the director of nursing (DON) stated she was aware R24 had a catheter, and that he'd refused to let staff take it out. The DON said the staff had routinely updated the NP, but stated she (the DON), was unaware whether the facility had documented orders to keep the catheter in or change it, and verified they should have gotten some type of orders since R24 had kept the Foley in. The DON also stated she was aware R24 had gone to the hospital on 10/1/15 to have his catheter changed. She stated his catheter had been reinserted in a surgical procedure. The DON also said R24 wanted the catheter, and would now go in every month to get the catheter changed. On 10/29/15, at 3:12 p.m. RN-F stated the normal protocol was most catheters were changed monthly, per specific doctor's orders. RN-F explained it was expected when a resident was admitted with a Foley catheter, the facility would obtain orders to discontinue it or at the time would look for clarification to determine why it was medically necessary. RN-F stated an order for catheter care should include directions for when to change the catheter. She stated she was new in her role as a nurse manager since September 2015. The Care Delivery policy for indwelling catheter dated 7/31/12, indicated the resident with an indwelling catheter for more than 14 days would be assessed for appropriate indications, that the catheter information would be on the plan of care along with the reason for the catheter, all residents with catheters would have ongoing monitoring and documentation in the nurse's progress notes, and that a resident's catheter	F 315		

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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F 315	Continued From page 27 would be changed more or less than every 30 days based on their assessment. Although the policy directed to assess the catheter, R24 lacked a re-assessment of the indwelling catheter and did not have an assessment as to how often the catheter should be changed.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care and services were provided to prevent aspiration for 1	F 322	1.Staff were inserviced on the Enteral Tube Feeding Policy including HOB elevated, as soon as notified about the	12/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 322	Continued From page 28 of 1 resident (R77) reviewed who utilized tube feedings. Finding include: On 10/27/15, at 9:58 a.m. R77 was observed to be in bed, with the HOB (head of bed) raised only about 10 degrees while a tube feeding (TF) was being infused via gastric tube (GT). On 10/27/15, at 11:30 a.m., R77 was again observed to be lying in bed without the HOB elevated more than 10 degrees while the tube feeding was being infused. On 10/28/15, at 7:45 a.m. R77 appeared asleep in bed. The HOB was again elevated only about 10 degrees while the TF was infused. At 9:30 a.m. the surveyor asked about R77's HOB elevation during tube feeding. Registered nurse (RN)-G immediately elevated the resident's HOB and stated, "the HOB should be elevated when the tube feeding is running, it should be at 45 degrees." On 10/29/15, from 7:01 to 7:04 a.m. during medication administration with licensed practical nurse (LPN)-A, the HOB was observed at 20 degrees upon entering the room and during the entire time LPN-A was administering medication via GT. LPN-A never elevated the HOB during the procedure. 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	F 322	concern during the annual survey. 2.R77 Nutrition and Bed mobility care plans have been reviewed and updated as needed. 3.Other residents with Enteral tube feedings have had their Nutrition and bed mobility care plans reviewed and revised as needed. 4.The facility Enteral Tube feeding policies have been reviewed and remain appropriate. 5.Staff will be in-serviced on the Enteral Tube feeding Policy. 6.Nursing leadership will complete bed mobility/HOB audits on all residents with enteral tube feeding 2x/week until the next QA&A committee meeting 12/15/15. 7.The facility QA&A committee will review completed audit results and make further recommendations. 8.See also F280. 9.The Director of Nursing and Dietician remain responsible for compliance with this requirement, to ensure that residents receiving gastrostomy feedings receive the appropriate treatment and services.	

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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F 322	Continued From page 29	F 322		

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."

R77's admission record indicated the resident had been admitted to the facility on 3/17/14, with diagnoses of dysphagia of the oropharyngeal phase, fracture of cervical vertebra, generalized weakness, use of GT, pulmonary embolus (blood clot affecting lungs/lung function) and respiratory failure.

R77's current Care Plan last updated 5/17/15, included problem areas of: "Nutrition Need, (eating, aspiration risk, etc.) as evidenced by tube feeding, and Need for artificial nutrition related to seizures and dysphagia as evidenced by need for enteral feeding through 'GT' tube." The goals included: "Resident to tolerate tube feeding (goal date of 1/27/16)." Interventions included: "Resident monitored at meals and when taking fluids; Appropriate referrals will be made; Adjustments will be made in the care of the resident to decrease the risk of aspiration; Notify MD [medical doctor] and obtain appropriate orders (thick liquids, etc.) Resident to be observed by staff at meals and when taking fluids; NPO [nothing by mouth] last updated 5/17/15; oral care every 2 hours; GT tube feeding- continue to monitor intake, weights and labs per facility protocol and intervene when appropriate; SLP [Speech Language Pathology] swallow clarification- Ok for nectar thick liquids via cup sip if sitting upright and supervised. Use small sips and chin tuck; Provide TF and H20 (water) as ordered." Although the care plan identified the tube feeding use, there were no

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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F 322	Continued From page 30	F 322		

interventions to direct staff related to the position of the bed during the GT feeding such as, how high the HOB should be to prevent potential aspiration.

An admission Care Area Assessment (CAA) dated 3/30/14, indicated R77 experienced cognitive loss with delusions and had been court committed to stay at the facility. The CAA indicated R77 had experienced a deterioration in overall activities of daily living and required staff to assist with daily cares. Although the R77 was assessed to have cognitive loss, and required staff assistance with daily care, the Nutritional Status and Feeding Tube CAA, indicated staff had advised R77 regarding positioning when the tube feeding was being infused, "advised resident that HOB needs to be 45 degrees while TF is running to prevent aspiration."

A significant change Minimum Data Set (MDS) dated 2/17/15, with corresponding CAAs dated 2/20/15, lacked assessment information about the continuous tube feeding, and lacked assessment for direction for staff about how high the HOB should be elevated to prevent potential aspiration.

The MDS dated 8/6/15, with corresponding CAA assessments dated 8/6/15, included mention of the tube feeding, but lacked assessment or direction for staff about how high the HOB should be elevated to prevent potential aspiration.

The NA care sheet last updated 10/26/15, failed to indicate directions for elevation of the HOB while R77 was receiving a tube feeding.

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	245267	A. BUILDING _____ B. WING _____	10/29/2015

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F 322	Continued From page 31 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. The facility's policy for Tube Feeding-Enteral dated 7/23/13, directed staff: 4. "Resident's with continuous enteral feeding must have their HOB 30 to 45 degrees at all times." 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 30º- 45º to prevent aspiration and pneumonia." The facility failed to implement standard of care precautions, and failed to follow facility policy related to aspiration precautions for tube feeding. Although a call was placed to R77's Primary Medical Doctor for comment, there was no return call.	F 322		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		12/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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ST ANTHONY 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
F 332	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R145) who utilized insulin FlexPen device observed for medication administration was free of medication errors. The medication error rate was at 7%. Findings include: R145's Physician's Orders dated 10/29/14, indicated R145 had an order for Glargine insulin (Lantus Solostar 15 units) subcutaneous two times daily for diabetes type II. On 10/26/15, at 7:09 p.m. registered nurse (RN)-H was observed set up R145's bedtime medications. During the set up RN-H was observed open the top draw of the medication cart obtained a Lantus Solostar Flexpen for R145 took the cap off obtained an AutoShield from a tote applied it to the top of the FlexPen without cleansing the rubber seal, dialed 15 units of insulin never primed the FlexPen with two units of insulin to pre-fill the needle. -At 7:11 p.m. RN-H went to R145's room and after administering oral medication was observed cleanse the right lower abdomen area let air dry then punched the area and using constant firm motion gave the insulin. -At 7:12 p.m. when asked what the facility policy 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." On 10/27/15, at 8:31 a.m. licensed practical nurse (LPN)-E was observed obtained the Lantus	F 332	1.Staff were in-serviced on the Soloflex Insulin pen as soon as notified about the concern during the annual survey. 2.Resident R145 Insulin orders have been reviewed. 3.All residents with an order for an Insulin Flex pen have had their physician orders reviewed. 4.PharMerica Nurse Consultant will conduct a medication administration in-service on 11/19/15. 5.Staff will be in-serviced on medication administration, including Insulin flex pens. 6.Nursing leadership will complete Insulin Flex Pens audits 2x/week until the next QA&A meeting on 12/15/15. 7.The facility QA&A committee will review completed audits and medication error reports monthly and make further recommendations. 8.See also F333. 9.The Director of Nursing remains responsible to ensure that the facility is free of medication error rates of 5% or greater.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 33 Solostar insulin for R145 took off the cap donned a pair of gloves opened the alcohol wrap wiped the rubber seal of the FlexPen applied the AutoShield on then dialed the pen to 15 units of insulin. As LPN-E was going into R145's room to administer insulin surveyor intervened, asked of LPN-E what were the manufacturer instructions for priming the insulin pen, LPN-E stated she had never primed the FlexPen before. LPN-E left the cart went over to the nursing station and was heard ask RN-F what the instructions were and during the conversation RN-F appeared confused and asked what surveyor meant by priming the pen. -At 8:35 a.m. RN-F nurse manager stated usually the nurses were just supposed to dial to the amount of insulin ordered for the resident. -At 8:36 a.m. surveyor and both nurses walked back to the cart and RN-F repeated to surveyor nurses were supposed to dial to the amount resident had ordered. When asked what the manufacturer instructions were again RN-F stated she would find out from the pharmacist. -At 8:48 a.m. the director of nursing (DON) stated "I don't understand what you mean by priming the pen I would expect the nurses to dial up the ordered amount." When surveyor was explaining what priming was DON then stated "I now know what you mean." -At 8:58 p.m. DON stated all nurses should have known the Flexpen was supposed to be primed and provided manufacturer instructions for the FlexPen which indicated the device was supposed to be pre-filled with two units. -At 9:03 a.m. DON was observed give LPN-E instructions then after LPN-E completed the procedure all over correctly with DON and surveyor present.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 34 On 10/27/15, at 3:56 p.m. medical director stated he did not administer medications and would not answer to it. When asked if he would have expected 12 units to be delivered as ordered MD agreed and added "if you're asking if there would be any harm if they got 10 or 14 units, no." On 10/29/15, at 3:30 p.m. via phone the consultant pharmacist (CP) stated "They should prime the pens according to the manufacturer ' s instructions" when the CP was asked if the nurses were supposed to prime the pens with two units of insulin to pre-fill the syringe prior to dialing the ordered amount. The package insert for Lantus Solostar dated March 2007 from Sanofi-Aventis U.S. LLC directed staff to: "Step 3. Perform a Safety test Always perform the Safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ·ensuring that pen and needle work properly ·removing air bubbles A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 332	Continued From page 35 ·If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. ·If still no insulin comes out, the needle may be blocked. Change the needle and try again. ·If no insulin comes out after changing the needle, your SoloStar® may be damaged. Do not use this SoloStar."	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to ensure residents were free of significant insulin administration errors for 1 of 4 residents (R145). Findings include: R145's Physician's Orders dated 10/29/14, indicated R145 had an order for Glargine insulin (Lantus Solostar 15 units) subcutaneous two times daily for diabetes type II. On 10/26/15, at 7:09 p.m. registered nurse (RN)-H was observed set up R145's bedtime medications. During the set up RN-H was observed open the top draw of the medication cart obtained a Lantus Solostar Flexpen for R145 took the cap off obtained an AutoShield from a tote applied it to the top of the FlexPen without cleansing the rubber seal, dialed 15 units of insulin never primed the FlexPen with two units	F 333	1.Staff were in-serviced on the Soloflex Insulin pen as soon as notified about the concern during the annual survey. 2.Resident R145 Insulin orders have been reviewed. 3.All residents with an order for an Insulin Flex pen have had their physician orders reviewed. 4.PharMerica Nurse Consultant will conduct a medication administration in-service on 11/19/15. 5.Staff will be in-serviced on medication administration, including Insulin flex pens. 6.Nursing leadership will complete Insulin Flex Pens audits 2x/week until the next QA&A meeting on 12/15/15. 7.The facility QA&A committee will review completed audits and medication error reports monthly and make further recommendations. 8.See also F332.	12/3/15

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F 333	Continued From page 36 of insulin to pre-fill the needle. -At 7:11 p.m. RN-H went to R145's room and after administering oral medication was observed cleanse the right lower abdomen area let air dry then punched the area and using constant firm motion gave the insulin. -At 7:12 p.m. when asked what the facility policy 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." On 10/27/15, at 8:31 a.m. licensed practical nurse (LPN)-E was observed obtained the Lantus Solostar insulin for R145 took off the cap donned a pair of gloves opened the alcohol wrap wiped the rubber seal of the FlexPen applied the AutoShield on then dialed the pen to 15 units of insulin. As LPN-E was going into R145's room to administer insulin surveyor intervened, asked of LPN-E what were the manufacturer instructions for priming the insulin pen, LPN-E stated she had never primed the FlexPen before. LPN-E left the cart went over to the nursing station and was heard ask RN-F what the instructions were and during the conversation RN-F appeared confused and asked what surveyor meant by priming the pen. -At 8:35 a.m. RN-F nurse manager stated usually the nurses were just supposed to dial to the amount of insulin ordered for the resident. -At 8:36 a.m. surveyor and both nurses walked back to the cart and RN-F repeated to surveyor nurses were supposed to dial to the amount resident had ordered. When asked what the manufacturer instructions were again RN-F stated she would find out from the pharmacist. -At 8:48 a.m. the director of nursing (DON) stated "I don't understand what you mean by priming the	F 333	9.The Director of Nursing remains responsible to ensure residents are free of any significant medication errors.	

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F 333	Continued From page 37	F 333		

pen I would expect the nurses to dial up the ordered amount." When surveyor was explaining what priming was DON then stated "I now know what you mean."
-At 8:58 p.m. DON stated all nurses should have known the Flexpen was supposed to be primed and provided manufacturer instructions for the FlexPen which indicated the device was supposed to be pre-filled with two units.
-At 9:03 a.m. DON was observed give LPN-E instructions then after LPN-E completed the procedure all over correctly with DON and surveyor present.

On 10/27/15, at 3:56 p.m. medical director stated he did not administer medications and would not answer to it. When asked if he would have expected 12 units to be delivered as ordered MD agreed and added "if you're asking if there would be any harm if they got 10 or 14 units, no."

On 10/29/15, at 3:30 p.m. via phone the consultant pharmacist (CP) stated "They should prime the pens according to the manufacturer ' s instructions" when the CP was asked if the nurses were supposed to prime the pens with two units of insulin to pre-fill the syringe prior to dialing the ordered amount.

The package insert for Lantus Solostar dated March 2007 from Sanofi-Aventis U.S. LLC directed staff to:
"Step 3. Perform a Safety test
Always perform the Safety test before each injection. Performing the safety test ensures that you get an accurate dose by:
·ensuring that pen and needle work properly
·removing air bubbles

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F 333	Continued From page 38 A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. ·If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. ·If still no insulin comes out, the needle may be blocked. Change the needle and try again. ·If no insulin comes out after changing the needle, your SoloStar® may be damaged. Do not use this SoloStar."	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 371	1. The link and kitchen have been	12/3/15

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F 371	Continued From page 39 review, the facility failed to ensure food sanitation procedures were followed to minimize the possibility of food borne illness in the main kitchen and hallway. This had the potential to affect 140 of 141 residents who eat food out of the kitchen. Findings include: During the kitchen tour on 10/26/15, at 11:44 a.m. the following was observed and confirmed by the registered dietitian (RD): - the 'link' hallway between the long term care kitchen and assisted living complex was unkempt, littered with leaves, heavy dirt and dust, with a buildup of a brown/black substance along the seam where the 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 leads to the outside dumpster area and employee smoking area. The hallway had numerous boxes and containers full of used kitchen equipment parts on the floor of the hallway, six uncovered rolling carts with clean resident use cups and mugs, two uncovered rolling carts with toasters and containers of cereal, three rolling carts with large coolers on the top shelf. Two of the three coolers had brown splatter like material on the outside and inside of the cover. RD stated the coolers were cleaned out after each meal service and she wasn't sure what the boxes of equipment were. At the end of the hallway, open employee lockers located directly across from the open dry storage area contained a plastic container of ice cream sprinkles dated 5/20, dry Chinese noodles stored in a plastic container labeled "chi noodles 7/2", a	F 371	cleaned and unnecessary items removed from the link and lockers. A professional cleaning company was hired to do a deep cleaning of all surfaces in the kitchen. 2. Staff will be re-trained on sanitary conditions of the kitchen and link using survey examples cited in the 2567. 3. Dining management has developed cleaning schedules to address all areas of the kitchen and link sanitation procedures. This will be monitored by the Director of Dining Services. Facility leadership will audit the kitchen and link 2X weekly until the next QA & A Meeting 12/15/15. 4. The Director of Dining Services will review the completed audits and bring any identified concerns to the facility QA & A Committee for review and further recommendations. 5. The Executive Director remains responsible for compliance with this requirement to ensure that sanitary conditions are met to minimize the possibility of food borne illness.	

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F 371	Continued From page 40 one gallon container of pancake/waffle syrup that was approximately 1/3 full dated 3/27, an undated one gallon container of molasses approximately 1/3 full, a large can of pumpkin opened approximately 1/4 of the can top with an opener. RD stated "I don't know what they are doing in here, they will be thrown out." - at the opposite end of the hallway directly inside an open door to the kitchen was an employee handwash sink, a two compartment sink verified by RD to be used to rinse off food and a six foot preparation table to the right of the sink. Behind this entire area there was a heavy buildup of black/brown food debris on and around all the table and sink legs and in the grout of the back floor tiles. The wall area behind the two compartment sink and handwash sink was splattered with brown food material. A baseboard wall tile across from the handwash sink was missing. RD confirmed this area was dirty and needed cleaning, stating "I know, I'm aware." - Walk in freezer floor had a heavy buildup of a sticky substance with food particles and debris located on the left side of the freezer, under the bottom shelving. The entrance corners to the freezer had a buildup of a brown/black substance. During the follow-up kitchen tour on 10/29/15, at 10:51 a.m. the following was observed and verified by the administrator (A), director of dining (DD) and administrator intern (AI): - Walk in cooler had a heavy buildup of a black/brown substance around all edges of the cooler, under all shelving and around all shelving	F 371		

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F 371	Continued From page 41 legs. Behind a small step stool on the left side there was a brown sticky substance on the floor. Across from the stool there was a buildup of food particles/debris littered on the floor under the shelving. - Wall behind the three compartment sink was heavily splattered with a brown substance. On and around all sink legs and back baseboard there was a brown/black buildup of food debris. The garbage disposal had a buildup of dust/dirt grime on the entire outside of the disposal. DD stated "yes I do see it." DD stated there are daily cleaning sheets that outline what staff is responsible to clean, "I don't have sign off sheets, it should be done daily." - Around the entire perimeter of the kitchen along the baseboards and on and around all legs of equipment there was a heavy buildup of black/brown grime and food debris. DD stated the floors are mopped two times a day and that there was no deep cleaning policy but "I will be making one soon." - 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."	F 371		

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F 371	Continued From page 42 During an interview on 10/29/15, at 12:26 p.m. DD stated all spills in the refrigerators or freezers should be cleaned as you go, "It's an expectation." Review of undated facility Miscellaneous Kitchen Cleaning List weekly cleaning indicated "1) pull out coolers and sweep and mop floors (Monday), 2) pull out all cooking equipment and sweep and mop floors (Tuesday), 3) sweep and mop out cooler and frezzer [sic] floors (wedesday) [sic], 4) delime dishwasher (Thursday), 5) sweep and mop storage room floor (Friday)."	F 371		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper containment of garbage in the outside dumpsters to prevent attracting pests for 1 of 1 trash storage area observed. Findings include: During the initial kitchen tour on 10/26/15, at 11:44 a.m. with the registered dietitian (RD), a brown dead rat was observed behind the large outside dumpster. RD stated "I will tell someone right away." To the right of the dumpster there were two plastic bags of trash laying on the ground next to a recycling container that was not	F 372	1. Rodent and trash bags were removed from the ground near the dumpsters, and all leaves were cleared from the area. 2. Staff have been in-serviced on the trash removal procedures and importance of placing items directly into the dumpster. 3. Environmental staff will complete audits 2X weekly until the next QA&A meeting 12/15/15. 4. Housekeeping Director will review completed audits and bring any identified concerns to the facility QA&A Committee for review and further recommendations. 5. The Executive Director remains	12/3/15

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F 372	Continued From page 43 covered. The trash was approximately 10 feet 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 dumpster and not on the ground. During an interview on 10/28/15, at 9:03 a.m. the maintenance director (MD) stated an outside pest 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 no pest activity inside the facility with 3 of 11 reports indicating a house mouse was located outside near the dumpster area. No garbage containment policy was provided.	F 372	responsible for compliance with this requirement to ensure that we do not attract pests in our trash storage areas.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		12/3/15

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F 425	Continued From page 44 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not have a system to ensure Fentanyl patches were accurately destroyed to prevent potential diversion for 2 of 2 residents (R145, R124). Findings include: 1 East Unit On 10/27/15, at 2:16 p.m. a tour of the medication cart was completed with registered nurse (RN)-G who provided access to the medication cart and the narcotic box. Inside the narcotic box to the back was observed an opened box of Fentanyl patches for R53. When asked what the facility procedure was for destroying used patches RN-G stated two nurses completed the destruction and would cut up patch in pieces and disposed it in the black box located in the medication room. RN-G stated the patch had been discontinued however indicated she was looking for the form where both nurses would sign after destroying the used patches. -At 2:27 p.m. RN-G approached stated she was not able to locate the documentation for the	F 425	1.Fentanyl destruction records were initiated at the time of survey for identified residents 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 in service for Licensed Nurses on 11/19/15. 4.Nursing Leadership will conduct narcotic/fentanyl patch audits weekly until the next QA&A meeting 12/15/15. 5.The facility QA&A committee will review completed audit results and make further recommendations. 6.The Director of Nursing remains responsible for compliance with this requirement to ensure that pharmaceutical services are provided to meet the needs of each resident.	

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F 425	Continued From page 45 patch destruction. 2 South East Unit: On 10/29/15, at 12:15 p.m. a medication cart tour was completed with licensed practical nurse (LPN)-E who provided access to the cart and the narcotic box. Inside the medication cart to the front were two boxes of Fentanyl patched for R124 and R145 with four and three patches left respectively. When reviewing the narcotic book it was revealed there was only one nurse signature throughout. When asked what the facility policy was for destroying the used patches, LPN-E stated another nurse would witness when destroying the patch however neither of the nurses documented the destruction anywhere. When asked if a progress note was done as evidence LPN-E stated, "No we don't." R145's Physician's Orders dated 10/29/14, indicated R145 had an order for the Fentanyl patch 72 hours 50 microgram (mcg)/hour (patch used for pain). R145's diagnoses included trauma leg amputation, chronic pain, neuropathy and gout obtained from quarterly Minimum Data Set (MDS) dated 9/18/15. During review of R145's Electronic Medication Administration Record (EMAR) dated 10/1/15, through 10/29/15, it was revealed R145 had the Fentanyl patch removed and disposed of ten times with only one nurse signing off. It could not be determined if there were two nurses as only one nurse signed off for applying of the Fentanyl patch no destruction/removal documentation.	F 425		

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F 425	Continued From page 46 R124's Physician's Orders dated 10/29/15, indicated R124 had an order for the Fentanyl patch 72 hours 25 mcg/hour. R124's diagnoses included chronic pain, pain in left hip, age related osteoporosis, polymyalgia rheumatica and history of traumatic fracture obtained from face sheet dated 10/29/15. During review of R124's Electronic Medication Administration Record (EMAR) dated 10/1/15, through 10/29/15, it was revealed R124 had the Fentanyl patch removed and disposed of ten times with only one nurse signing off. It could not be determined if there were two nurses as only one nurse signed off for applying of the Fentanyl patch no destruction/removal documentation. On 10/29/15, at 2:59 p.m. the director of nursing (DON) stated she was not aware nurses were not aware of the form they needed to complete when destroying Fentanyl patches. DON stated the 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. In	F 425		

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F 425	Continued From page 47 addition the policy and procedure did not address the disposition of Fentanyl patches to prevent 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.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		12/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	10/29/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 48 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure that 2 of 2 medication carts on the subacute unit were locked. This had the potential to affect 19 of 27 residents on the sub acute unit. Findings include: During random continuous observation on 10/28/15, at 9:01 a.m. sub acute medication cart one was left unlocked when registered nurse (RN)-D walked away toward the front lobby. -9:02 a.m. a therapy staff member and male resident passed the unlocked medication cart. -9:03 a.m. nursing assistant (NA)-A passed the cart. -9:04 a.m. RN-A returned to the nursing unit and sat at the desk and printed out papers. -9:05 a.m. a housekeeper passed unlocked medication cart. -9:07 a.m. a therapy staff member past the medication cart. -9:08 a.m. a female resident passed the unlocked	F 431	1.The Medication Administration and Storage policy has been reviewed. 2.PharMerica Nurse Consultant will conduct a medication administration in-service on 11/19/15. 3.Staff will be in-serviced on medication administration using specific survey examples. 4.Nursing Leadership will conduct medication cart audits 2x/week until the next QA&A meeting 12/15/15. 5.The facility QA&A committee will review completed audit results and make further recommendations. 6.The Director of Nursing remains responsible for compliance with this requirement to ensure that pharmaceutical services are provided to meet the needs of each resident.	

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F 431	Continued From page 49	F 431		

medication cart. No nurse was at the desk or visible in hallway.
-9:09 a.m. RN-D returned to medication cart one and locked it.

During random continuous observation on 10/28/15, at 9:16 a.m. sub acute medication cart two was left unlocked when RN-E went into an office.
-9:18 a.m. RN-D locked sub acute medication cart two.

During interview on 10/28/15, at 9:09 a.m. RN-D verified that medication cart one was left unlocked. RN-D stated the medication carts contained blood pressure medications, insulin (a medication for treatment of elevated blood sugars), coumadin (a blood thinner) and various creams.

During interview on 10/28/15, at 9:35 a.m. RN-C subacute nurse manager stated a medication cart should be locked if out of the nurses reach. The nurse should at least be able to see the cart. RN-C stated it would not be ok to have medication carts unlocked while sitting at the desk or if their back to it.

During interview on 10/28/15, at 9:40 a.m. RN-E stated, "I don't usually leave my medication cart unlocked. I wanted to catch the doctor to update him about a resident's condition."

During interview on 10/29/15, at 2:32 p.m. director of nursing she stated, "When a medication cart is out of the nurses line of sight, it should be locked. If the nurses are at a desk across hall from cart--if it is in their line of sight, it

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F 431	Continued From page 50 can be unlocked." Storage of Medication Policy dated 09/10, indicated ..."Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		12/3/15

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F 441	Continued From page 51 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures was used for 1 of 3 residents (R43) reviewed for morning cares. The facility failed to disinfect an insulin pen prior to attaching the needle for 1 of 4 residents (R145) during insulin administration. This deficient practice also had the potential to affect three other residents who utilized insulin pens. 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	F 441	1.The facility Infection Control policy and procedures has been reviewed 2.Staff will be in-serviced on Infection Control (hand washing) and Insulin flex pens using specific survey examples. 3.The nursing leadership will complete NAR care audits and Insulin flex pen administration audits 2x/week until the next QA&A meeting on 12/15/15. 4.The Director of Nursing will review completed audits and bring any identified concerns to the facility QA&A committee for further recommendations. 5.The Director of Nursing remains responsible for compliance with this requirement to ensure a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection.	

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F 441	Continued From page 52 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. NA-E came into the room indicated R43 was in her group and was going to get her ready for the day. NA-D indicated to R43 NA-E was going to get her ready. -At 7:36 a.m. to 7:39 a.m. both NAs continued to assist R43 with cares and cleaned her upper body including the back and applied socks and pants half way as they cued R43. -At 7:40 a.m. NA-D cued R43 to open her legs then completed pericare in the front. Then both NA's cued R43 to roll as NA-D cleansed her bottom which was noted to have brown green bowel movement. 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, then reached over to her right side scrubs pocket got one glove out but never applied it. NA-D then indicated to NA-E she was going outside the room to get the R43's wheelchair. Still not washed her hands NA-D left the room went outside the hallway wheeled R43's wheelchair into the room. Both NAs were observed adjust R43's pants then both NA's cued R43 they were going to assist her to get seated at the edge of bed before 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. At 7:44 a.m. with both NAs standing to R43's side 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.	F 441		

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F 441	Continued From page 53	F 441		

NA-D then went on to comb R43's hair and applied eye glasses never washed hands still.
-At 7:49 a.m. after leaving R43's room NA-D was observed enter room 241 and that time surveyor intervened and when asked about hand washing. NA-D acknowledged she had not washed her hands after providing pericare with stool observed stated "I will wash my hands right now" as NA-D entered room 241.

On 10/28/15, at 1:11 p.m. registered nurse (RN)-F stated it was the facility policy for staff to wash hands before applying and after removing gloves. RN-F further stated staff was supposed to have removed gloves and washed hands if they had provided pericare and with stool being involved the staff was supposed to wash their hands with soap and water before proceeding with cares.

On 10/29/15, at 9:07 a.m. LPN-D unit nurse manager stated when asked about hand washing "Staff are supposed to wash their hands before and after removing their gloves, before providing cares, before leaving the room."

Hand Hygiene policy dated 10/8/15, directed:
"1. Hand hygiene requirements:
a. Whenever hands are visibly contaminated or soiled.
b. Before and after contact with residents.
c. After contant with contaminated environmental surfaces adjacent to the resident.
d. Before assisting residents with eating or handling food.
e. After toileting or assisting residents with toileting, handling of urinals, bedpans,

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F 441	Continued From page 54 catheters, soiled linen, towels, wash cloths. f. Before and after smoking or eating. g. After coughing, sneezing, or blowing of nose and or assisting residents after coughing, sneezing and blowing of nose. h. After handling uncooked animal products, such as raw meat or fish. i. Before performing a resident care ADL procedure and after removal of gloves if worn..." Disinfect an insulin pen prior to attaching the needle On 10/26/15, at 7:09 p.m. RN-H was observed set up R145's bedtime medications. During the set up RN-H R145 was observed open the top draw of the medication cart obtained a Lantus Solostar Flexpen for R145 took the cap off obtained an AutoShield from a tote applied it to the top of the FlexPen without cleansing the rubber seal with alcohol and dialed 15 units of insulin. -At 7:11 p.m. RN-H went to R145's room and after administering oral medication was observed cleanse the right lower abdomen area let air dry then punched the area and using constant firm motion gave the insulin. -At 7:12 p.m. when asked when asked if he was supposed to cleanse the rubber seal prior to applying the AutoShield RN-H stated "I usually clean the rubber seal top of the old insulin vial" RN-H acknowledged he should have cleaned the rubber seal. On 10/29/15, at 2:59 p.m. the director of nursing (DON) stated the nurse was supposed to cleanse the rubber seal just as they did for the vial. In	F 441		

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F 441	Continued From page 55 addition the DON stated staff were supposed to follow hand washing policy when providing cares. 2/15, Lantus SoloStar Instruction Leaflet directed users to "Wipe The Rubber Seal with alcohol" then attach the needle.	F 441		

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	245267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Anthony Health Center is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1997, an addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 150 beds and had a	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 2 census of 138 at the time of the survey. A K-067 has been written in past surveys. upon further detailed investigation it has been found that The supply and return for the 1967 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/29/2015, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Director (BS) revealed the that the facility could not provide any documentation verifying that 2 of the 12 monthly testing of the battery backup emergency lights had been completed.	K 046	1. The facility will keep monthly records indicating that the emergency battery backup lighting has been tested. 2. December 3, 2015 3. The Director of Maintenance will review completed records monthly to ensure compliance. Maintenance Director will bring any concerns to be reviewed monthly at the QA&A Meeting.	12/3/15

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

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K 046	Continued From page 3 This deficient practices was confirmed by the Maintenance Director (BS).	K 046		

MINNESOTA MDH DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00522	A. BUILDING: _____ B. WING _____	10/29/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 26th, 27th, 28th and 29th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, facility failed to check and change a resident in accordance with their plan of care, for 1 of 3 (R289) residents observed for activities of daily living. Findings include: The Care Plan Report dated 10/28/15, instructed R289 had an alteration in bowel and bladder function and instructed staff to toilet the resident upon rising, before and after meals, with night rounds and as needed. R289 was to be checked and change two hours. The nursing assistant (NA) undated assignment sheet indicated R289 incontinent of bladder. Resident Care Summary POC undated instructed staff "Check and change Q 2hr" copy requested but not received.	2 565	Corrected	12/3/15

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2 565	Continued From page 3 Continuous observation on 10/28/15, from 7:06 a.m. until 10:47 a.m. noted the following: -7:06 a.m. Resident was sleeping in room. -7:42 a.m. Nursing assistant (NA)-A explained to R289 that they were going to help R289 get up and get dressed. NA-A opened incontinent brief and attempted to wash R289 up. -7:51 a.m. NA-A and NA-C told R289 that they would tell the nurse that R289 did not want to get up. NA-A instructed R289 to use call light to call for assistance when ready to get up and left room. R289 lying in bed covered with a sheet. The resident had on red anti slip socks and black slacks that were partially pulled up legs. Incontinent pad was open under R289's buttocks. -8:00 a.m. registered nurse (RN)-D spoke with R289. R289 agreed to get up for breakfast. -8:22 a.m. NA-A and NA-B informed R289 that they were here to get R289 up for breakfast - 8:40 a.m. NA-A and NA-B put a dry incontinence product on R289. -8:55 a.m. R289 on way to dining room. -9:21:25 AM R289 brought to sitting area next to nursing station. -10:28 a.m. Activities-A took resident to church . -10:42 a.m. Resident at church at Chandler Place. -10:47 a.m. Church service started. -11:34 a.m. Activities staff-A informed surveyor R289 was back on unit. R289 did not stop any where on way back. R289 did not go to the bathroom while at church. R289 was seated next to desk. -11:50 a.m. R289 taken to room and incontinent pad checked. R289 was dry. During interview on 10/28/15, at 10:45 a.m. Activities staff-A stated, "I let the staff know before I took R289 off the unit."	2 565		

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2 565	Continued From page 4 During interview on 10/28/15, at 11:41 a.m. NA-A stated, "After [R289] ate [R289] went to therapy and now she is back, we are to toilet R298 after breakfast. I have not toileted R289 yet." During interview on 10/28/15, at 12:25 p.m. RN-C stated I would expect them to attempt toileting, check and change every 2 hours. I would expect the staff to follow the plan of care. RN-C verified the correct toileting plan was to check and change R289 every two hours. During interview on 10/29/15, at 2:35 p.m. director of nurses (DON) verified expected staff to follow check and change every two hours if on plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff to follow care plans in regards to specific resident cares and services. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of	2 570		12/3/15

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2 570	Continued From page 5 the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the plan of care was revised for 1 of 1 resident (R77) which included keeping the head of bed elevated to prevent aspiration during continuous tube feedings. Findings include: On 10/27/15, at 9:58 a.m. R77 was observed to be in bed, with the HOB raised only about 10 degrees while a tube feeding was being infused via gastric tube (GT). On 10/27/15, at 11:30 a.m., R77 was again observed to be lying in bed without the HOB elevated more than 10 degrees. A tube feeding was observed to be running at 70 ml's per hour via GT. On 10/28/15, at 7:45 a.m. R77 appeared asleep in bed. R77 was lying on back, but was crooked in the bed. R77's head was toward wall and left foot partially off bed and the lower extremities were edematous. The HOB approximately 10 degrees of elevation, with the TF attached and running at 70 ml's/hr. -At 9:30 a.m. staff were prompted to observe R77, when staff entered the room, registered nurse (RN)-G immediately elevated the HOB, and stated when asked "the HOB should be elevated when the tube feeding was running, should be at 45 degrees."	2 570	Corrected	

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2 570	Continued From page 6 On 10/29/15, from 7:01 to 7:04 a.m., during medication administration with licensed practical nurse (LPN)-A, the HOB was observed at 20 degrees upon entering the room and during the entire time LPN-A was administering medication. LPN-A never elevated the HOB during the procedure, R77 appeared to be asleep with eyes closed during the entire procedure. R77's admission record indicated the resident had been admitted to the facility on 3/17/14, with diagnoses of dysphagia of the oropharyngeal phase, fracture of cervical vertebra, generalized weakness, use of gastric tube (GT) (gastric tube feeding (TF) directly to the stomach by a tube inserted through the skin), pulmonary embolus (blood clot affecting lungs/lung function) and respiratory failure. R77's Care Plan dated 3/17/14, to present indicated: Problem areas: "Nutrition Need, (eating, aspiration risk, etc.) as evidenced by tube feeding, and Need for artificial nutrition related to seizures and dysphagia as evidenced by need for enteral feeding through 'GT' tube." Goals included: "Resident to tolerate tube feeding (goal date of 1/27/16) " Interventions included: "Resident monitored at meals and when taking fluids; Appropriate referrals will be made; Adjustments will be made in the care of the resident to decrease the risk of aspiration; Notify MD [medical doctor] and obtain appropriate orders (thick liquids, etc.) Resident to be observed by staff at meals and when taking fluids; NPO [nothing by mouth] last updated 5/17/15; oral care every 2 hours; GT tube feeding- continue to monitor intake, weights and labs per facility protocol and intervene when appropriate; SLP [Speech Language Pathology]	2 570		

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2 570	Continued From page 7 swallow clarification- Ok for nectar thick liquids via cup sip if sitting upright and supervised. Use small sips and chin tuck; Provide TF and H20 (water) as ordered." Although the care plan identified the tube feeding use, there were no interventions to direct staff related to the position of the bed during the GT feeding such as, how high the HOB should be to prevent potential aspiration, nor was there any indication on the care plan that the resident refused any treatment such as having the HOB elevated, due to comfort. 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 running at 70 ml's per hour. At 9:47 the LPN-A was brought into the room to observe R77, and verified the HOB should not be flat, and LPN-A elevated the HOB to 30 degrees. LPN-A listened the resident lungs and stated the "lungs were clear." - At 11:11 a.m. RN-B stated the HOB should always be between 45 to 90 degrees to prevent risk of aspiration. - At 2:17 pm the director of nursing (DON) stated the HOB should be elevated as much as tolerated 45 degrees, the DON verified best practice would be to have the HOB elevated at a minimum 30 degrees to prevent aspiration. The facility policy for Tube Feeding-Enteral dated 7/23/13, directed staff: 4. "Resident's with continuous enteral feeding must have their HOB 30 to 45 degrees at all times." 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 30º - 45º to prevent aspiration	2 570		

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2 570	Continued From page 8 and pneumonia." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for accuracy of care plans to add resident cares and services when a change is warranted. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and provide appropriate care and services for 1 of 2 patients (R24) reviewed who had an indwelling Foley catheter (a thin, sterile	2 910	Corrected	12/3/15

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2 910	Continued From page 9 tube inserted into the bladder to drain urine which can be left in place for a period of time). Findings include: During observation on 10/28/15, at 3:43 p.m. R24 was observed to have a Foley catheter tube and drainage bag containing clear yellow urine. At that time, R24 stated he'd had the Foley catheter in place for six months or better and had recently had to go to the hospital to have it changed. R24's current care plan printed on 10/28/15, indicated R24 had problems including: "alteration in urinary elimination related to diabetic as evidenced by Foley catheter in use and history of antibiotic medication for a diagnosis of UTI [urinary tract infection]" and "Indwelling catheter for diagnosis of urinary retention with obstruction secondary to renal failure. A hospital readmission Clinical Note dated 5/5/15, indicated R24 had been readmitted with an indwelling Foley catheter. A note from 5/8/15, indicated staff had been going to remove the catheter, but R24 had "requested to have the Foley removed tomorrow morning (5/9/15)." The Clinical Notes indicated the catheter remained in place until 9/29/15, when a nurse removed and attempted (unsuccessfully) to reinsert it. The Clinical Notes dated 9/29/15, indicated R24 was ordered to have indwelling catheter changed during morning shift due to risk for infection. "Writer tried two times to insert new Foley using a 16 F [French, a unit of measurement] catheter but was unsuccessful. NP [nurse practitioner] then ordered a Coude' tip Foley catheter" [a bent tip that maneuvers around obstructions leading to the bladder], which was the type of catheter that	2 910		

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2 910	Continued From page 10	2 910		

had originally been inserted in the hospital in May. "Writer, with the assistance of another floor nurse manager tried the procedure, yet unable to complete task. NP gave order to send resident to ER [emergency room] for further evaluation if unsuccessful. [R24] informed with above order but declined at this time. Resident stated 'I have been voiding now'. Nursing monitoring [R24's] output throughout shift for possible retention and intervene as appropriate."

The Clinical Notes dated 9/29/15, R24 was ordered to have indwelling catheter changed during morning shift due to risk for infection. "Writer tried two times to insert new Foley using a 16 F catheter but was unsuccessful. NP then ordered a Coude' tip Foley catheter [a bent tip that maneuvers around obstructions leading to the bladder] which was originally inserted from the hospital. Writer, with the assistance of another floor nurse manager tried the procedure, yet unable to complete task. NP gave order to send resident to ER [emergency room] for further evaluation if unsuccessful. [R24] informed with above order but declined at this time. Resident stated 'I have been voiding now'. Nursing monitoring [R24's] output throughout shift for possible retention and intervene as appropriate."

On 9/30/15, the Clinical Notes indicated R24 "was monitored all night, voided 350 cc [cubic centimeters] yellow color, no signs/symptoms of infection." Another Clinical Note from 9/30/15 included: "without Foley catheter. Had 750 cc output, 0 cc bladder scan PVR [post void residual]. R24 asking for tomorrow's appointment time. Daily schedule with no appointment information, was informed will update tomorrow." Clinical notes from 10/1/15, indicated: "today's hospital appointment was to put catheter in, told

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2 910	Continued From page 11	2 910		

no appointment at this time, writer to call NP to update regarding output and bladder scan result from yesterday. [R24] saying 'I don't care whatever she said I need to and I want to go to put catheter in right now, you hear me', NP updated on output and bladder scan yesterday, okay to send to ER to put catheter in per [R24] request." The notes indicated R24 was sent to the hospital 10/1/15, at 10:15 a.m. for catheter insertion.

The hospital Discharge Summary Note indicated R24 had been sent to the hospital 10/1/15 for an indwelling catheter replacement and had urine culture completed which was positive for a UTI, so antibiotics had been initiated for R24.

A Clinical Note entry dated 10/2/15, at 3:55 p.m. indicated the resident had arrived back at the facility: "Foley intact, output 800 cc, urine yellow, was started on Cipro 500 milligrams [mg] x 7 days for UTI." The notes also indicated R24 had returned with orders related to the Foley including; to be seen by urology monthly for catheter replacement, and for nursing to continue to monitor for signs/symptoms of infection and adjust per resident's needs.

Further review of R24's medical record lacked any indication that the catheter had been changed from 5/5/15 to 9/29/15. In addition, physician and nurse practitioner notes from 5/7/15 through 10/1/15, were reviewed. Their notes did not address the indwelling catheter prior to his hospitalization for catheter replacement and infection. In addition, the Physician Order Sheets prior to 10/2/15, lacked any direction for staff to provide care and treatment of the indwelling catheter such as; size of catheter, balloon size, what signs and symptoms to monitor for, and

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2 910	Continued From page 12 when to replace the indwelling catheter. The facility's form, Bowel and Bladder Evaluation dated 5/10/15, indicated R24 was continent of bladder with Foley catheter placed. This evaluation revealed R24 was at risk for incontinence due to being immobile, and was cognitively impaired - made poor decisions, and was dependent upon two staff for transfers. The evaluation did not address diagnoses which could have affected continence, i.e.., kidney calculi and CHF (congestive heart failure) which had been present at the time of admission per the 5/15 hospital discharge documents. The evaluation also did not include a review of medications that could affect kidney dysfunction such as: use of a diuretic (Bumex), antidepressant use (Effexor), antianxiety use (hydroxyzine), and use of narcotic pain medication (Oxycontin and oxycodone PRN [as needed]). Each of these medications were included on the May 2015 Physician Order Sheet. Although Bowel and Bladder Evaluation indicated a trial period of urinary retraining had been done with no improvement, there was no documentation on the Evaluation, nor in the Clinical notes to indicate when such retraining had been attempted prior to the removal of the catheter 9/29/15. On the Evaluation form there was a section identified as: Evaluation For Residents With Indwelling Catheters. This section included indications for a Foley such as: identifying need for exact measurement of urine output, diagnoses such as unstageable pressure ulcers, terminal illness, severe impairment and movement with intractable pain, or untreatable urethral blockage causing urinary retention (documented by PVR of over 200 milliliters (ml) and staff unable to perform intermittent catheterization (three failed attempts). This section of the Bowel and Bladder Evaluation form	2 910		

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	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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2 910	Continued From page 13 indicated residents with indwelling catheters should meet at least one of the identified conditions, however R24 did not meet any. Finally, the Evaluation form failed to indicate any removal plan, or risks of complications resulting from the use of a catheter such as infection, blockage, bypassing urine, pain, discomfort, bleeding or expulsion. A quarterly Minimum Data Set (MDS) dated 7/10/15, indicated R24 had diagnoses of diabetes, renal insufficiency and neurogenic bladder with an indwelling Foley catheter. The MDS indicated R24 was cognitively intact. On 10/2/15, a new Bowel and Bladder Evaluation form was completed at 11:16 a.m.. The Evaluation again indicated R24 was continent of bladder with Foley catheter placed. The evaluation revealed the same outcome as the prior form completed 5/5/15, with this exception: R24 was at risk for incontinence due to being immobile, and was cognitively impaired - made poor decisions, and was dependent upon two staff for transfers. In addition, the form indicated R24 had antianxiety (hydroxyzine and lorazepam), and a narcotic used for pain control (Oxycontin, morphine sulfate, and oxycodone PRN) as indicated per the October 2015 Physician Order Sheet. In addition, the Physician Order Sheet post 10/2/15 directed staff to have R24 seen by the urologist every month for a catheter change due to urinary retention. This Evaluation form remained incomplete regarding R24 diagnoses and still not include a removal plan or risks/complications resulting from the use of a catheter such as infection, blockage, bypassing urine, pain, discomfort, bleeding or expulsion.	2 910		

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2 910	Continued From page 14 On 10/29/15, at 9:03 a.m. registered nurse (RN)-F was interviewed. RN-F confirmed R24's catheter had been removed on 9/29/15. RN-F further verified the nurse had not been able to reinsert a catheter so they'd initiated monitoring output, and had updated the MD. RN-F stated R24 had been sent to the hospital for Foley replacement on 10/1/15, and had been admitted. She further verified that when R24 came back to the facility, he had new orders for monthly catheter replacement by urology. RN-F stated there had not previously been orders for monthly catheter change including size or type of catheter. On 10/29/15, at 2:44 p.m. the director of nursing (DON) stated she was aware R24 had a catheter, and that he'd refused to let staff take it out. The DON said the staff had routinely updated the NP, but stated she (the DON), was unaware whether the facility had documented orders to keep the catheter in or change it, and verified they should have gotten some type of orders since R24 had kept the Foley in. The DON also stated she was aware R24 had gone to the hospital on 10/1/15 to have his catheter changed. She stated his catheter had been reinserted in a surgical procedure. The DON also said R24 wanted the catheter, and would now go in every month to get the catheter changed. On 10/29/15, at 3:12 p.m. RN-F stated the normal protocol was most catheters were changed monthly, per specific doctor's orders. RN-F explained it was expected when a resident was admitted with a Foley catheter, the facility would obtain orders to discontinue it or at the time would look for clarification to determine why it was medically necessary. RN-F stated an order for catheter care should include directions for when to change the catheter. She stated she was new	2 910		

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2 910	Continued From page 15 in her role as a nurse manager since September 2015. The Care Delivery policy for indwelling catheter dated 7/31/12, indicated the resident with an indwelling catheter for more than 14 days would be assessed for appropriate indications, that the catheter information would be on the plan of care along with the reason for the catheter, all residents with catheters would have ongoing monitoring and documentation in the nurse's progress notes, and that a resident's catheter would be changed more or less than every 30 days based on their assessment. Although the policy directed to assess the catheter, R24 lacked a re-assessment of the indwelling catheter and did not have an assessment as to how often the catheter should be changed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures related to indwelling Foley catheters. The DON could develop an audit tool and could monitor the provision of catheter care. In addition, the DON could provide staff education related to following facility protocols/policies for appropriate care of residents who have have catheters. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding	2 930		12/3/15

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2 930	Continued From page 16 syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care and services were provided to prevent aspiration for 1 of 1 resident (R77) reviewed who utilized tube feedings. Finding include: On 10/27/15, at 9:58 a.m. R77 was observed to be in bed, with the HOB (head of bed) raised only about 10 degrees while a tube feeding (TF) was being infused via gastric tube (GT). On 10/27/15, at 11:30 a.m., R77 was again observed to be lying in bed without the HOB elevated more than 10 degrees while the tube feeding was being infused. On 10/28/15, at 7:45 a.m. R77 appeared asleep in bed. The HOB was again elevated only about 10 degrees while the TF was infused. At 9:30 a.m. the surveyor asked about R77's HOB elevation during tube feeding. Registered nurse (RN)-G immediately elevated the resident's HOB	2 930	Corrected	

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2 930	Continued From page 17 and stated, "the HOB should be elevated when the tube feeding is running, it should be at 45 degrees." On 10/29/15, from 7:01 to 7:04 a.m. during medication administration with licensed practical nurse (LPN)-A, the HOB was observed at 20 degrees upon entering the room and during the entire time LPN-A was administering medication via GT. LPN-A never elevated the HOB during the procedure. 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." R77's admission record indicated the resident had been admitted to the facility on 3/17/14, with diagnoses of dysphagia of the oropharyngeal phase, fracture of cervical vertebra, generalized weakness, use of GT, pulmonary embolus (blood clot affecting lungs/lung function) and respiratory failure. R77's current Care Plan last updated 5/17/15, included problem areas of: "Nutrition Need, (eating, aspiration risk, etc.) as evidenced by tube feeding, and Need for artificial nutrition related to seizures and dysphagia as evidenced by need for enteral feeding through 'GT' tube." The goals included: "Resident to tolerate tube feeding (goal date of 1/27/16)." Interventions included: "Resident monitored at meals and when taking fluids; Appropriate referrals will be made;	2 930		

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2 930	Continued From page 18 Adjustments will be made in the care of the resident to decrease the risk of aspiration; Notify MD [medical doctor] and obtain appropriate orders (thick liquids, etc.) Resident to be observed by staff at meals and when taking fluids; NPO [nothing by mouth] last updated 5/17/15; oral care every 2 hours; GT tube feeding- continue to monitor intake, weights and labs per facility protocol and intervene when appropriate; SLP [Speech Language Pathology] swallow clarification- Ok for nectar thick liquids via cup sip if sitting upright and supervised. Use small sips and chin tuck; Provide TF and H20 (water) as ordered." Although the care plan identified the tube feeding use, there were no interventions to direct staff related to the position of the bed during the GT feeding such as, how high the HOB should be to prevent potential aspiration. An admission Care Area Assessment (CAA) dated 3/30/14, indicated R77 experienced cognitive loss with delusions and had been court committed to stay at the facility. The CAA indicated R77 had experienced a deterioration in overall activities of daily living and required staff to assist with daily cares. Although the R77 was assessed to have cognitive loss, and required staff assistance with daily care, the Nutritional Status and Feeding Tube CAA, indicated staff had advised R77 regarding positioning when the tube feeding was being infused, "advised resident that HOB needs to be 45 degrees while TF is running to prevent aspiration." A significant change Minimum Data Set (MDS) dated 2/17/15, with corresponding CAAs dated 2/20/15, lacked assessment information about the continuous tube feeding, and lacked assessment for direction for staff about how high	2 930		

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2 930	Continued From page 19 the HOB should be elevated to prevent potential aspiration. The MDS dated 8/6/15, with corresponding CAA assessments dated 8/6/15, included mention of the tube feeding, but lacked assessment or direction for staff about how high the HOB should be elevated to prevent potential aspiration. The NA care sheet last updated 10/26/15, failed 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. The facility's policy for Tube Feeding-Enteral dated 7/23/13, directed staff: 4. "Resident's with continuous enteral feeding must have their HOB 30 to 45 degrees at all times." 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 30º- 45º to prevent aspiration and pneumonia." The facility failed to implement standard of care precautions, and failed to follow facility policy related to aspiration precautions for tube feeding.	2 930		

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2 930	Continued From page 20 Although a call was placed to R77's Primary Medical Doctor for comment, there was no return call. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents with tube feedings have the head of the bed placed at the right height to prevent potential aspiration. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food sanitation procedures were followed to minimize the possibility of food borne illness in the main kitchen and hallway. This had the potential to affect 140 of 141 residents who eat food out of the kitchen. Findings include:	21015	Corrected	12/3/15

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21015	Continued From page 21 During the kitchen tour on 10/26/15, at 11:44 a.m. the following was observed and confirmed by the registered dietitian (RD): - the 'link' hallway between the long term care kitchen and assisted living complex was unkempt, littered with leaves, heavy dirt and dust, with a buildup of a brown/black substance along the seam where the 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 leads to the outside dumpster area and employee smoking area. The hallway had numerous boxes and containers full of used kitchen equipment parts on the floor of the hallway, six uncovered rolling carts with clean resident use cups and mugs, two uncovered rolling carts with toasters and containers of cereal, three rolling carts with large coolers on the top shelf. Two of the three coolers had brown splatter like material on the outside and inside of the cover. RD stated the coolers were cleaned out after each meal service and she wasn't sure what the boxes of equipment were. At the end of the hallway, open employee lockers located directly across from the open dry storage area contained a plastic container of ice cream sprinkles dated 5/20, dry Chinese noodles stored in a plastic container labeled "chi noodles 7/2", a one gallon container of pancake/waffle syrup that was approximately 1/3 full dated 3/27, an undated one gallon container of molasses approximately 1/3 full, a large can of pumpkin opened approximately 1/4 of the can top with an opener. RD stated "I don't know what they are doing in here, they will be thrown out." - at the opposite end of the hallway directly inside an open door to the kitchen was an employee handwash sink, a two compartment sink verified by RD to be used to rinse off food and a six foot	21015		

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21015	Continued From page 22 preparation table to the right of the sink. Behind this entire area there was a heavy buildup of black/brown food debris on and around all the table and sink legs and in the grout of the back floor tiles. The wall area behind the two compartment sink and handwash sink was splattered with brown food material. A baseboard wall tile across from the handwash sink was missing. RD confirmed this area was dirty and needed cleaning, stating "I know, I'm aware." - Walk in freezer floor had a heavy buildup of a sticky substance with food particles and debris located on the left side of the freezer, under the bottom shelving. The entrance corners to the freezer had a buildup of a brown/black substance. During the follow-up kitchen tour on 10/29/15, at 10:51 a.m. the following was observed and verified by the administrator (A), director of dining (DD) and administrator intern (AI): - Walk in cooler had a heavy buildup of a black/brown substance around all edges of the cooler, under all shelving and around all shelving legs. Behind a small step stool on the left side there was a brown sticky substance on the floor. Across from the stool there was a buildup of food particles/debris littered on the floor under the shelving. - Wall behind the three compartment sink was heavily splattered with a brown substance. On and around all sink legs and back baseboard there was a brown/black buildup of food debris. The garbage disposal had a buildup of dust/dirt grime on the entire outside of the disposal. DD stated "yes I do see it." DD stated there are daily cleaning sheets that outline what staff is responsible to clean, "I don't have sign off sheets,	21015		

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21015	Continued From page 23 it should be done daily." - Around the entire perimeter of the kitchen along the baseboards and on and around all legs of equipment there was a heavy buildup of black/brown grime and food debris. DD stated the floors are mopped two times a day and that there was no deep cleaning policy but "I will be making one soon." - 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." During an interview on 10/29/15, at 12:26 p.m. DD stated all spills in the refrigerators or freezers should be cleaned as you go, "It's an expectation." Review of undated facility Miscellaneous Kitchen Cleaning List weekly cleaning indicated "1) pull out coolers and sweep and mop floors (Monday), 2) pull out all cooking equipment and sweep and mop floors (Tuesday), 3) sweep and mop out cooler and frezzer [sic] floors (wedesday) [sic], 4) delime dishwasher (Thursday), 5) sweep and mop storage room floor (Friday)." SUGGESTED METHOD FOR CORRECTION: The Administrator and the Dietician could review and revise food service policies and procedures	21015		

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21015	Continued From page 24 to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		12/3/15

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21390	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand washing measures was used for 1 of 3 residents (R43) reviewed for morning cares. In addition, the facility failed to disinfect an insulin pen prior to attaching the needle for 1 of 4 residents (R145) during insulin administration. This deficient practice also had the potential to affect three other residents who utilized insulin pens. 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 get her ready for the day. NA-D indicated to R43	21390	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21390	Continued From page 26 NA-E was going to get her ready. -At 7:36 a.m. to 7:39 a.m. both NAs continued to assist R43 with cares and cleaned her upper body including the back and applied socks and pants as they cued R43. -At 7:40 a.m. NA-D cued R43 to open her legs then completed pericare in the front. Then both NA's cued R43 to roll as NA-D cleansed her bottom which was noted to have brown green bowel movement. 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, then reached over to her right side scrubs pocket got one glove out but never applied it. NA-D then indicated to NA-E she was going outside the door to get the R43's wheelchair. Still not washed her hands NA-D left the room went outside the hallway wheeled R43's wheelchair into the room. Both NAs were observed adjust R43's pants then both NA's cued R43 they were going to assist her to get seated at the edge of bed before 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. At 7:44 a.m. with both NAs standing to R43's side 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. NA-D then went on to comb R43's hair and applied eye glasses never washed hands still. -At 7:49 a.m. after leaving R43's room NA-D was observed enter room 241 and that time surveyor intervened and when asked about hand washing. NA-D acknowledged she had not washed her hands after providing pericare with stool observed stated "I will wash my hands right now" as NA-D entered room 241. On 10/28/15, at 1:11 p.m. registered nurse	21390		

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21390	Continued From page 27 (RN)-F stated it was the facility policy for staff to wash hands before applying and after removing gloves. RN-F further stated staff was supposed to have removed gloves and washed hands if they had provided pericare and with stool being involved the staff was supposed to wash their hands with soap and water before proceeding with cares. On 10/29/15, at 9:07 a.m. LPN-D unit nurse manager stated when asked about hand washing "Staff are supposed to wash their hands before and after removing their gloves, before providing cares, before leaving the room." The facility's Hand Hygiene policy dated 10/8/15, directed: "1. Hand hygiene requirements: a. Whenever hands are visibly contaminated or soiled. b. Before and after contact with residents. c. After contant with contaminated environmental surfaces adjacent to the resident. d. Before assisting residents with eating or handling food. e. After toileting or assisting residents with toileting, handling of urinals, bedpans, catheters, soiled linen, towels, wash cloths. f. Before and after smoking or eating. g. After coughing, sneezing, or blowing of nose and or assisting residents after coughing, sneezing and blowing of nose. h. After handling uncooked animal products, such as raw meat or fish. i. Before performing a resident care ADL procedure and after removal of gloves if worn..."	21390		

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21390	Continued From page 28 Disinfect an insulin pen prior to attaching the needle On 10/26/15, at 7:09 p.m. RN-H was observed set up R145's bedtime medications. During the set up RN-H R145 was observed open the top draw of the medication cart obtained a Lantus Solostar Flexpen for R145 took the cap off obtained an AutoShield from a tote applied it to the top of the FlexPen without cleansing the rubber seal with alcohol and dialed 15 units of insulin. -At 7:11 p.m. RN-H went to R145's room and after administering oral medication was observed cleanse the right lower abdomen area let air dry then punched the area and using constant firm motion gave the insulin. -At 7:12 p.m. when asked when asked if he was supposed to cleanse the rubber seal prior to applying the AutoShield RN-H stated "I usually clean the rubber seal top of the old insulin vial" RN-H acknowledged he should have cleaned the rubber seal. On 10/29/15, at 2:59 p.m. the director of nursing (DON) stated the nurse was supposed to cleanse the rubber seal just as they did for the vial. In addition the DON stated staff were supposed to follow hand washing policy when providing cares. The protocol dated 2/15, from the Lantus SoloStar Instruction Leaflet directed users to "Wipe The Rubber Seal with alcohol" then attach the needle. SUGGESTED METHOD FOR CORRECTION: The DON could review and revise the policies and procedures related to handwashing and cleansing of the rubber of the insulin pens before medication administration. She or designee could provide education to all involved staff. The	21390		

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21390	Continued From page 29 facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure to complete Baseline tuberculosis (TB) Screening Tool for Nursing Home and Boarding Care Home Residents for 5	21426	Corrected	12/3/15

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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. 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	21426		

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21426	Continued From page 31 policy dated 8/3/15, indicated: "4 The Tuberculosis Screen form will be placed in the residents medical record file or appropriate file based on health care facilities practices." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility did not have a system to ensure Fentanyl patches were accurately destroyed to prevent potential diversion for 2 of 2 residents (R145, R124).	21525	Corrected	12/3/15

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21525	Continued From page 32 Findings include: 1 East Unit On 10/27/15, at 2:16 p.m. a tour of the medication cart was completed with registered nurse (RN)-G who provided access to the medication cart and the narcotic box. Inside the narcotic box to the back was observed an opened box of Fentanyl patches for R53. When asked what the facility procedure was for destroying used patches RN-G stated two nurses completed the destruction and would cut up patch in pieces and disposed it in the black box located in the medication room. RN-G stated the patch had been discontinued however indicated she was looking for the form where both nurses would sign after destroying the used patches. -At 2:27 p.m. RN-G approached stated she was not able to locate the documentation for the patch destruction. 2 South East Unit: On 10/29/15, at 12:15 p.m. a medication cart tour was completed with licensed practical nurse (LPN)-E who provided access to the cart and the narcotic box. Inside the medication cart to the front were two boxes of Fentanyl patched for R124 and R145 with four and three patches left respectively. When reviewing the narcotic book it was revealed there was only one nurse signature throughout. When asked what the facility policy was for destroying the used patches, LPN-E stated another nurse would witness when destroying the patch however neither of the nurses documented the destruction anywhere. When asked if a progress note was done as evidence LPN-E stated, "No we don't."	21525		

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21525	Continued From page 33 R145's Physician's Orders dated 10/29/14, indicated R145 had an order for the Fentanyl patch 72 hours 50 microgram (mcg)/hour (patch used for pain). R145's diagnoses included trauma leg amputation, chronic pain, neuropathy and gout obtained from quarterly Minimum Data Set (MDS) dated 9/18/15. During review of R145's Electronic Medication Administration Record (EMAR) dated 10/1/15, through 10/29/15, it was revealed R145 had the Fentanyl patch removed and disposed of ten times with only one nurse signing off. It could not be determined if there were two nurses as only one nurse signed off for applying of the Fentanyl patch no destruction/removal documentation. R124's Physician's Orders dated 10/29/15, indicated R124 had an order for the Fentanyl patch 72 hours 25 mcg/hour. R124's diagnoses included chronic pain, pain in left hip, age related osteoporosis, polymyalgia rheumatica and history of traumatic fracture obtained from face sheet dated 10/29/15. During review of R124's Electronic Medication Administration Record (EMAR) dated 10/1/15, through 10/29/15, it was revealed R124 had the Fentanyl patch removed and disposed of ten times with only one nurse signing off. It could not be determined if there were two nurses as only one nurse signed off for applying of the Fentanyl patch no destruction/removal documentation. On 10/29/15, at 2:59 p.m. the director of nursing (DON) stated she was not aware nurses were not aware of the form they needed to complete when destroying Fentanyl patches. DON stated the	21525		

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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 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 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		

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21545	Continued From page 35	21545		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		12/3/15

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21545	Continued From page 36 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R145) who utilized insulin FlexPen device observed for medication administration was free of medication errors. The medication error rate was at 7%. Findings include: R145's Physician's Orders dated 10/29/14, indicated R145 had an order for Glargine insulin (Lantus Solostar 15 units) subcutaneous two times daily for diabetes type II. On 10/26/15, at 7:09 p.m. registered nurse (RN)-H was observed set up R145's bedtime medications. During the set up RN-H was observed open the top draw of the medication cart obtained a Lantus Solostar Flexpen for R145 took the cap off obtained an AutoShield from a tote applied it to the top of the FlexPen without cleansing the rubber seal, dialed 15 units of insulin never primed the FlexPen with two units of insulin to pre-fill the needle. -At 7:11 p.m. RN-H went to R145's room and after administering oral medication was observed cleanse the right lower abdomen area let air dry then punched the area and using constant firm motion gave the insulin. -At 7:12 p.m. when asked what the facility policy	21545	Corrected	

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21545	Continued From page 37 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." On 10/27/15, at 8:31 a.m. licensed practical nurse (LPN)-E was observed obtained the Lantus Solostar insulin for R145 took off the cap donned a pair of gloves opened the alcohol wrap wiped the rubber seal of the FlexPen applied the AutoShield on then dialed the pen to 15 units of insulin. As LPN-E was going into R145's room to administer insulin surveyor intervened, asked of LPN-E what were the manufacturer instructions for priming the insulin pen, LPN-E stated she had never primed the FlexPen before. LPN-E left the cart went over to the nursing station and was heard ask RN-F what the instructions were and during the conversation RN-F appeared confused and asked what surveyor meant by priming the pen. -At 8:35 a.m. RN-F nurse manager stated usually the nurses were just supposed to dial to the amount of insulin ordered for the resident. -At 8:36 a.m. surveyor and both nurses walked back to the cart and RN-F repeated to surveyor nurses were supposed to dial to the amount resident had ordered. When asked what the manufacturer instructions were again RN-F stated she would find out from the pharmacist. -At 8:48 a.m. the director of nursing (DON) stated "I don't understand what you mean by priming the pen I would expect the nurses to dial up the ordered amount." When surveyor was explaining what priming was DON then stated "I now know what you mean." -At 8:58 p.m. DON stated all nurses should have known the Flexpen was supposed to be primed and provided manufacturer instructions for the FlexPen which indicated the device was supposed to be pre-filled with two units.	21545		

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ST ANTHONY 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) COMPLETE DATE
21545	Continued From page 38 -At 9:03 a.m. DON was observed give LPN-E instructions then after LPN-E completed the procedure all over correctly with DON and surveyor present. On 10/27/15, at 3:56 p.m. medical director stated he did not administer medications and would not answer to it. When asked if he would have expected 12 units to be delivered as ordered MD agreed and added "if you're asking if there would be any harm if they got 10 or 14 units, no." On 10/29/15, at 3:30 p.m. via phone the consultant pharmacist (CP) stated "They should prime the pens according to the manufacturer ' s instructions" when the CP was asked if the nurses were supposed to prime the pens with two units of insulin to pre-fill the syringe prior to dialing the ordered amount. The package insert for Lantus Solostar dated March 2007 from Sanofi-Aventis U.S. LLC directed staff to: "Step 3. Perform a Safety test Always perform the Safety test before each injection. Performing the safety test ensures that you get an accurate dose by: · ensuring that pen and needle work properly · removing air bubbles A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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

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21545	Continued From page 39 times before insulin is seen. · If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. · If still no insulin comes out, the needle may be blocked. Change the needle and try again. · If no insulin comes out after changing the needle, your SoloStar® may be damaged. Do not use this SoloStar." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to medication administration, preventing significant medication errors and/or medication transcription processes. Responsible personnel could be re-educated on these policies and procedures. The medication regimen for the individual(s) identified in the deficiency could be reviewed for accuracy and appropriateness, with supporting documentation maintained. An investigation could be completed to determine the root cause of this significant medication error, with corrective action implemented to prevent similar errors from occurring in the future. The medication regimens of other residents could be evaluated for appropriate transcription processes and administration. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21545		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage	21610		12/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21610	Continued From page 40 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure that 2 of 2 medication carts on the subacute unit were locked. This had the potential to affect 19 of 27 residents on the sub acute unit. Findings include: During random continuous observation on 10/28/15, at 9:01 a.m. sub acute medication cart one was left unlocked when registered nurse (RN)-D walked away toward the front lobby. -9:02 a.m. a therapy staff member and male resident passed the unlocked medication cart. -9:03 a.m. nursing assistant (NA)-A passed the cart. -9:04 a.m. RN-A returned to the nursing unit and sat at the desk and printed out papers. -9:05 a.m. a housekeeper passed unlocked medication cart. -9:07 a.m. a therapy staff member past the medication cart. -9:08 a.m. a female resident passed the unlocked medication cart. No nurse was at the desk or visible in hallway. -9:09 a.m. RN-D returned to medication cart one and locked it. During random continuous observation on 10/28/15, at 9:16 a.m. sub acute medication cart two was left unlocked when RN-E went into an office.	21610	Corrected	

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	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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21610	Continued From page 41 -9:18 a.m. RN-D locked sub acute medication cart two. During interview on 10/28/15, at 9:09 a.m. RN-D verified that medication cart one was left unlocked. RN-D stated the medication carts contained blood pressure medications, insulin (a medication for treatment of elevated blood sugars), coumadin (a blood thinner) and various creams. During interview on 10/28/15, at 9:35 a.m. RN-C subacute nurse manager stated a medication cart should be locked if out of the nurses reach. The nurse should at least be able to see the cart. RN-C stated it would not be ok to have medication carts unlocked while sitting at the desk or if their back to it. During interview on 10/28/15, at 9:40 a.m. RN-E stated, "I don't usually leave my medication cart unlocked. I wanted to catch the doctor to update him about a resident's condition." During interview on 10/29/15, at 2:32 p.m. director of nursing she stated, "When a medication cart is out of the nurses line of sight, it should be locked. If the nurses are at a desk across hall from cart--if it is in their line of sight, it can be unlocked." Storage of Medication Policy dated 09/10, indicated ..."Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and	21610		

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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21610	Continued From page 42 procedures to ensure medications are appropriately stored. 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.	21610		
21735	MN Rule 4658.1420 Solid Waste Disposal Solid wastes, including garbage, rubbish, recyclables, and other refuse must be collected, stored, and disposed of in a manner that will not create a nuisance or fire hazard, nor provide a breeding place for insects or rodents. Accumulation of combustible material or waste in unassigned areas is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper containment of garbage in the outside dumpsters to prevent attracting pests for 1 of 1 trash storage area observed. Findings include: During the initial kitchen tour on 10/26/15, at 11:44 a.m. with the registered dietitian (RD), a brown dead rat was observed behind the large outside dumpster. RD stated "I will tell someone right away." To the right of the dumpster there were two plastic bags of trash laying on the ground next to a recycling container that was not covered. The trash was approximately 10 feet	21735	Corrected	12/3/15

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	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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

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21735	Continued From page 43 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 dumpster and not on the ground. During an interview on 10/28/15, at 9:03 a.m. the maintenance director (MD) stated an outside pest 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 no pest activity inside the facility with 3 of 11 reports indicating a house mouse was located outside near the dumpster area. No garbage containment policy was provided. 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 ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21735		

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21805	Continued From page 44	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 4 of 5 residents (R43, R77, R289, R291) cares were provided in a dignified manner. Findings include: R43's diagnosis included anxiety, glaucoma, cataract, mild cognitive impairment, Osteoporosis, muscle weakness, major depression and osteoarthritis obtained from form the Face Sheet dated 10/29/15. 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.	21805	Corrected	12/3/15

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21805	Continued From page 45 -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. Privacy curtain was not pulled around the bed. -At 7:35 a.m. NA-E entered the room indicated R43 was in her group and was going to get her ready for the day. -At 7:36 a.m. to 7:39 a.m. both NA's were observed remove R43's hospital gown and proceeded to wipe her upper body including the back then pat dried the area did not cover R43. NA-E then applied socks and pants half way. Still R43's breast exposed. -At 7:40 a.m. NA-D cued R43 to open her legs then completed pericare in the front. Then both NA's cued R43 to roll as NA-D cleansed her bottom. NA-D removed the soiled gloves and never washed her hands, went over to the dresser by the wall across from R43's bed and indicated the glove box was empty, then reached over to her right side scrubs pocket got one glove out but never applied it. NA-D then indicated to NA-E she was going outside the room to get R43's wheelchair. NA-D left the room went outside the hallway left the door wide open as NA-E was standing at resident bed applying the incontinent pad with resident breast still exposed and privacy curtain not pulled. Surveyor followed out and was able to see R43's entire body when standing in the hallway looking into the room. NA-D then wheeled R43's wheelchair into the room shut the door. Both NAs were observed adjust R43's pants then cued R43 they were going to assist her to get seated at the edge of bed before 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. -At 7:44 a.m. with both NAs standing to R43's	21805		

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

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21805	Continued From page 46	21805		

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 of the weather and being cold. Staff are also supposed to pull the privacy curtain with cares all the time that is my expectation."

On 10/29/15, at 3:00 p.m. the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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21805	Continued From page 47 (DON) stated she would have expected staff to provide for privacy during cares. Acknowledged was a dignity concern. Activities of daily living (ADL's) Care Area Assessment (CAA) dated 2/5/15, indicated R43 required extensive assistance with dressing bathing and personal hygiene. R77's diagnoses included depression, schizophrenia and use of gastric tube (GT) (tube feeding (TF) obtained from the quarterly Minimum Data Set (MDS) dated 8/11/15. On 10/29/15, at 7:01 to 7:10 a.m. LPN-A was observed set R77's medications. -At 7:11 a.m. both LPN-A and surveyor went to room to observe medication administration via gastrostomy tube (GT). LPN-A stated to R77 she was going to administer morning medications. Upon entering room, R77 was lying on her back, eye closed and the head of bed was at approximately 20 degrees. LPN-A set the medication on the bedside pull table went to the bathroom, obtained water in a cylinder (measuring device) and applied gloves. LPN-A then disconnected the tube feeding cleansed the end with alcohol hang it up on the pool. Stated to resident she was going to listen to her stomach then after administered medications via GT. During the entire observation time door was wide open and the privacy curtain was pulled to the length of the roommate's bed. -At 7:16 a.m. R77's roommate got out of bed came around and picked into R77's side stood there briefly then went over to the dresser and walked past R77's area/space as she went into the shared bathroom. LPN-A still administering medications.	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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

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21805	Continued From page 48 On 10/29/15, at 12:07 p.m. LPN-A acknowledged she had neither closed the door nor pulled the privacy curtain during the procedure. LPN-A stated it was supposed to have been done to provide R77 privacy. On 10/29/15, at 2:59 p.m. the director of nursing stated, "If the resident was exposed she would have expected the nurse to have shut the door and pulled the privacy curtain." On 10/29/15, at 1:34 p.m. a dignity policy was requested but the director of nursing stated "We do not have a dignity policy. We follow the resident rights." R289's admission MDS dated 10/23/15, indicated R289 was severely cognitively impaired and required assistance with all ADLs. R289's MDS indicated R289 was frequently incontinent of bowel and bladder. R289's MDS included diagnosis of dementia and depression. Continuous observation on 10/28/15, from 7:06 a.m. until 10:47 a.m. -7:06 a.m. Resident was sleeping in room. -7:38 a.m. Nursing assistant (NA)-A entered R289's room and stated it was time to get up. -7:39 a.m. NA-A left to get help. -7:40 a.m. NA-A returned to R289's room. -7:41 a.m. NA-C knocked on the door and entered the room without waiting for acknowledgement. -7:42 a.m. Explained what they were going to do and encouraged R289 to get dressed. R289 said "I am afraid." NA-C used a soothing voice to explain staff were here to help R289 get dressed and encouraged R289 to roll over so NA-A could	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 49	21805		

wash R289's bottom. R289 would not turn over and just held NA-C's hand.
-7:51 a.m. NA-A and NA-C told R289 they would tell the nurse R289 did not want to get up. NA-A instructed R289 to use call light to call for assistance when ready to get up and left room. R289 lying in bed covered with a sheet. R289's face appeared distressed, eyes narrowed, lips trembling. clutching top of sheet. R289 stated "I am so frightened." Resident had on red anti slip socks and black slacks that were partially pulled up legs. Incontinence pad was open under R289's buttocks.
-8:09 a.m. Resident lying on bed staring at ceiling hand clenched on sheets.
-8:22 a.m. NA-A and NA-B entered R289's room without knocking. NA-A and NA-B informed R289 that they were here to get R289 up for breakfast. NA-A stated to NA-B, "The nurse said she will get her up." NA-B handed R289 a wash cloth and encouraged R289 to wash face and praised R289 for doing a good job. R289 refused to have underarms washed. NA-A said over R289's head, "see [R289] doesn't want cares."
-8:34 a.m. RN-D knocked and entered without waiting for a response. RN-D encouraged R289 to get up for breakfast. R289 said, "I feel so lost." NA-A rolled his head and eyes towards the ceiling.
-8:51 a.m. RN-D Left the room. NA-A stated "This is where the fight is going to happen." After R289 was up and dressed the resident went to breakfast.

During interview on 10/28/15, at 9:28 a.m. RN-D stated, "I thought I knocked but I am so busy today."

During interview on 10/28/15, at 10:32 a.m. NA-A stated, "I am so nervous I must have forgotten to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 50 knock." During interview on 10/29/15, at 2:35 p.m. the DON stated she expected staff to knock and wait for a response before entering a room. The DON stated she would not expect staff to roll head at resident comments. R291's Face Sheet printed 10/29/15, indicated R291 diagnoses included aphasia (difficulty communicating) and diabetes. Physician Order Sheet printed 10/29/15, instructed staff to check R291's blood sugars four times a day. During a blood sugar observation on 10/29/15, at 4:30 p.m. LPN-B entered R291's room and explained the procedure. LPN-B put the glucometer (a machine for checking blood sugars) bucket down on over the bed table without a barrier between the bucket and over the bed table. LPN-B washed hands and turned the water off. LPN-B cleaned glucometer with a PDI wipe and allowed to dry for two minutes. LPN-B put on clean gloves, wiped R291's finger with an alcohol wipe. LPN-B pricked R291's finger, wiped off the first drop of blood and took a drop of blood on test strip. LPN-B put the glucometer down on barrier. Cleaned glucometer with PDI wipes and let dry. LPN-B wrapped glucometer in paper towel and put it in the bucket. LPN-B removed gloves and washed hands, turning off facet with bare hands. During the entire procedure the door to the room was open and privacy curtain was not pulled to afford R291 privacy. On 10/29/15, at 4:43 p.m. R291 said, "I wish he had shut the door."	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 51 During interview on 10/29/15, at 4:45 p.m. LPN-B acknowledged, "I did not shut the door while checking the blood sugar. I should have." The facility's Our Platinum Service Standards form undated directed staff be considerate and treat residents with dignity and respect. SUGGESTED METHOD OF CORRECTION: The administrator or social services could in-service all staff on the residents rights so they can be promoted for each resident. TIME PERIOD FOR CORRECTION: Fourteen (14) days. .	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 3 residents (R77) reviewed for	21810	Corrected	12/3/15

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	00522	A. BUILDING: _____ B. WING _____	C 10/29/2015

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21810	Continued From page 52 incontinence and who were capable of using the call light. Findings include: On 10/27/15, at 9:58 a.m. during R77 room observation the call light was observed on floor on the other side of bed not accessible to R77. Both registered nurse (RN)-K and RN-L verified the call light was not at reach. -At 10:00 a.m. when asked if she was able to use the call light R77 shook her head and when asked to demonstrate R77 was not able to put the call light on as the cord was wrapped up with other strings which made it hard for her to use her call light. On 10/29/15, at 2:59 p.m. the director of nursing stated the call light was supposed to be at reach for all residents who were capable of using it. R77's diagnoses included abnormality of gait, general muscle weakness, major depression and mild cognitive impairment obtained from the care plan report dated 11/6/15. R77's care plan for falls dated 11/6/15, identified R77 at risk for fall as evidenced by history of fall with neck injury. The care plan directed staff to keep "Call light within reach [left] (L) side bed enabler bar." In addition the care plan indicated "Resident has also been reminded to use her call light for assistance with any needs and she verbalized understanding to the counsel." On 10/29/15, at 3:00 p.m. the call light policy was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and	21810		

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21810	Continued From page 53 procedures to ensure call lights are kept within resident reach. 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.	21810		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter	21980		12/3/15

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21980	Continued From page 54 knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure bruises of unknown origin were immediately reported to the administrator and State agency (SA) for 1 of 4 residents (R55) reviewed for incidents. Findings include: R55 had a diagnoses that included general muscle weakness, dementia and depression listed on the Face Sheet dated 4/21/15. The annual Minimum Data Set (MDS) dated 5/15/15, indicated R55 had severe cognitive impairment and required extensive assistance of two staff for	21980	Corrected	

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21980	Continued From page 55 bed mobility, dressing, locomotion and toileting. An incident report dated 4/20/15, indicated during evening cares, nursing assistant (NA)-I alerted licensed practical nurse (LPN)-F about a bruise to R55's left inner gluteal area on 4/18/15. LPN-F noted the cause was unknown. Registered nurse (RN)-J assessed the bruise with RN-F on 4/20/15. The bruise was noted to be 11 centimeters (cm) X 6 cm, dark purple in color and located on the inner aspect of the left buttock covering an area near the coccyx and anus. R55 was unaware of how the bruise occurred. The director of nursing (DON) and executive director (ED) were notified of incident on 4/20/15 and an investigation initiated. During interview on 10/29/15, at 1:28 p.m. DON stated she was not sure why they were notified two days later, "we report injuries of unknown origin." The DON, ED and SA all were notified on 4/20/15, two days after the bruise of unknown origin was discovered. The facility Vulnerable Adult Abuse Prohibition policy dated 10/2006, indicated that mandated reporters will immediately report to the administrator/executive director and that the facility shall report immediately to the Common Entry Point. The policy further outlined that unexplained injuries, therapeutic error with injury, neglect, abuse in part defined as "the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which could be considered threatening" and financial exploitation shall be reported.	21980		

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21980	Continued From page 56 SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately reporting suspected abuse to the designated state agency/common entry point. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.	22000		12/3/15

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22000	Continued From page 57 (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prevention policy for immediately notifying the administrator and State Agency (SA) regarding an alleged violation regardingbruises of unknown origin for 1 of 4 residents (R55) whose incidents were reviewed. Findings include: The facility Vulnerable Adult Abuse Prohibition policy dated 10/06, indicated mandated reporters will immediately report to the administrator/executive director and that the facility shall report immediately to the Common Entry Point. The policy further outlined that	22000	Corrected	

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22000	Continued From page 58 unexplained injuries, therapeutic error with injury, neglect, abuse in part defined as "the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which could be considered threatening" and financial exploitation shall be reported. R55 had a diagnoses that included general muscle weakness, dementia and depression listed on the Face Sheet dated 4/21/15. The annual Minimum Data Set dated 5/15/15, indicated R55 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, dressing, locomotion and toileting. An incident report dated 4/20/15, indicated during evening cares, nursing assistant (NA)-I alerted licensed practical nurse (LPN)-F about a bruise to R55's left inner gluteal area on 4/18/15. LPN-F noted the cause was unknown. Registered nurse (RN)-J assessed the bruise with RN-F on 4/20/15. The bruise was noted to be 11 centimeters (cm) X 6 cm, dark purple in color and located on the inner aspect of the left buttock covering an area near the coccyx and anus. R55 was unaware of how the bruise occurred. The director of nursing (DON) and exucutive director (ED) notified of incident on 4/20/15. Investigation initiated. During interview on 10/29/15, at 1:28 p.m. DON stated she was not sure why they were notified two days later, "we report injuries of unknown origin." The DON, ED and SA all were notified on 4/20/15, two days after the bruise of unknown origin was discovered.	22000		

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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) days.	22000		