



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 31, 2024

Administrator
St Anthony Park Home Inc
2237 Commonwealth Avenue
Saint Paul, MN 55108

RE: CCN: 245063
Cycle Start Date: October 8, 2024

Dear Administrator:

On October 14, 2024, we notified you a remedy was imposed. On October 25, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 9, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 14, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 8, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 31, 2024

Administrator
St Anthony Park Home Inc
2237 Commonwealth Avenue
Saint Paul, MN 55108

Re: Reinspection Results
Event ID: JLP912

Dear Administrator:

On October 25, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 8, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
October 14, 2024

Administrator
St Anthony Park Home Inc
2237 Commonwealth Avenue
Saint Paul, MN 55108

RE: CCN: 245063
Cycle Start Date: October 8, 2024

Dear Administrator:

On October 8, 2024, survey was completed at your facility by the Minnesota Department of Health 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 4, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 29, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 29, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective

St Anthony Park Home Inc

October 14, 2024

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October 29, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 8, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

St Anthony Park Home Inc

October 14, 2024

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Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Anthony Park Home Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 8, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 8, 2025 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of

St Anthony Park Home Inc

October 14, 2024

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law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 14, 2024

Administrator
St Anthony Park Home Inc
2237 Commonwealth Avenue
Saint Paul, MN 55108

Re: State Nursing Home Licensing Orders
Event ID: JLP911

Dear Administrator:

The above facility was surveyed on October 3, 2024 through October 8, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

St Anthony Park Home Inc

October 14, 2024

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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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2024
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NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 10/3/24, 10/4/24 and 10/8/24, an abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed during the survey: H50639221C (MN00107036)</p> <p>The survey resulted in an Immediate Jeopardy (IJ) to resident safety. An IJ at F689 began on 9/27/24 when the facility failed to provide adequate supervision for 1 of 3 residents (R1) who was at risk for elopement, eloped from the facility and was found half a block away. The administrator and director of nursing (DON) were informed of the IJ on at 10/3/24 at 4:53 p.m.</p> <p>The above findings constituted Substandard Quality of Care and an extended survey was conducted on 10/4/24.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/23/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2024
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(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 F 689 SS=J	<p>Continued From page 1 regulations has been attained.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) who was at risk for elopement. This resulted in an immediate jeopardy (IJ) for R1 when he eloped from the facility and was found half a block away.</p> <p>The IJ began on 9/27/24 at 4:00 p.m. when therapy director (TD)-A discovered R1 outside of the facility on the sidewalk, approximately half a block from the building. The administrator and director of nursing (DON) were informed of the IJ on 10/3/24 at 4:53 p.m. The IJ was removed on 10/4/24, but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>R1's Face Sheet dated 10/4/24 indicated R1 had diagnoses of Alzheimer's disease, traumatic brain injury, and dementia.</p>	F 000 F 689	<p>It is the policy of St Anthony Park Home to follow all Federal, State, and local guidelines, laws, regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission and implementation of this plan of correction will serve as our credible allegation of compliance.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>R1 interviewed and no lasting effect noted related to elopement. R1 wander guard was changed and retested for proper functionality. Staff educated on R1 care plan requiring 30-minute checks and need</p>	10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2024
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(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 689	<p>Continued From page 2</p> <p>R1's significant change Minimum Data Set (MDS) dated 7/31/24 indicated R1 had severe cognitive impairment. The MDS also identified R1 used a wander/elopement alarm daily.</p> <p>R1's Elopement Risk Assessment dated 9/5/24 indicated R1 was at risk for elopement.</p> <p>R1's care plan dated 6/3/24 indicated R1 was at risk for elopement and wandering, and utilized a WanderGuard management system (used to trigger alarms to alert staff when a resident wearing a WanderGuard bracelet is near a door). Interventions indicated WanderGuard was on left wrist, and R1 had wandering safety checks every thirty minutes.</p> <p>R1's Treatment Administration Record dated 6/3/24 indicated staff to check WanderGuard placement every shift, check function weekly, and change WanderGuard every 90 days.</p> <p>On 9/27/24 at 6:08 p.m., a progress note written by registered nurse (RN)-D indicated R1 was found ambulating on the sidewalk approximately half a block from the facility, and assisted back to the facility by staff. R1's WanderGuard was checked and replaced.</p> <p>On 10/3/24 at 9:16 a.m., licensed practical nurse (LPN)-A stated she didn't check R1's WanderGuard to ensure it was functioning on 9/24/24, but she charted she had checked it in R1's electronic medical record (EMR) "accidentally." She stated she didn't replace R1's WanderGuard on 9/23/24, but she did chart in R1's EMR it was completed. LPN-A did not offer an</p>	F 689	<p>for supervision should R1 be outside.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected by the deficient practices. Staff educated on wanderguard policy and residents wearing wanderguard bracelet. All residents with wanderguard bracelets are checked daily for functionality.</p> <p>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur</p> <ul style="list-style-type: none"> * Review/revise the WanderGuard policy to ensure WanderGuards are being checked for functionality daily per manufacturer's directions. * Reeducate all staff on the WanderGuard policy. * Ensure all resident WanderGuards are working correctly. <p>How the facility will monitor its corrective actions to ensure that the deficient practice being corrected and will not recur.</p> <p>Audits of daily wander guard checks will be performed 3x week for 2 weeks, 2x week for 2 weeks, 1x week for 1 month. Audits to be reviewed at monthly quality meetings and assessed for need of continuance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2024
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(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 689	<p>Continued From page 3</p> <p>explanation as to why she charted she had replaced it, when in fact, she had not.</p> <p>On 10/3/24 at 9:24 a.m., R1 stated he left the facility and they found him on the farm. He stated he does not remember where he was going. He stated he plans on leaving the facility again to go to his wife's house.</p> <p>On 10/3/24 at 11:22 a.m., RN-B stated on 9/27/24 around 3:15 p.m., she saw R1 come off the elevator onto the first floor with RN-A. She told RN-A that R1 was on thirty-minute checks, and asked RN-A to take R1 back to his room. She stated RN-A walked outside with R1, and the alarm didn't go off for R1's WanderGuard. RN-A then went back into the facility a few minutes later and told her (RN-B) R1 was at the patio. RN-B thought RN-A had brought R1 back up to his room. At around 4:00 p.m., therapy director (TD)-A brought R1 back to the facility, and said she had found R1 walking on the sidewalk on Como Avenue. R1's WanderGuard bracelet did not alarm when R1 entered the facility.</p> <p>On 10/3/24 at 12:24 p.m., RN-D stated on 9/27/24 at around 4:10 p.m., TD-A notified her R1 was found on the sidewalk on Como Avenue and was brought back to the facility. She stated R1's WanderGuard was not triggering the alarm system to sound, so RN-D changed R1's WanderGuard at that time.</p> <p>On 10/3/24 at 12:59 p.m., TD-A stated on 9/27/24 around 4:03 p.m., she was driving home from work and spotted R1 on Como Avenue walking toward Commonwealth Street. She turned her car around</p>	F 689	The date that each deficiency will be corrected: October 09, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2024
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
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F 689	<p>Continued From page 4</p> <p>to pick him up after he crossed Commonwealth Street, and she brought him back to the facility.</p> <p>On 10/3/24 at 1:10 p.m., RN-A stated on 9/27/24 around 3:30 p.m., she got on the elevator and R1 was on the elevator. She walked outside with R1, R1 sat down at a chair in the front patio area, and she went back into the facility. She told RN-B she had to go back upstairs, and asked RN-B to keep an eye on R1. RN-A went back to the second floor. Later that shift, RN-A was told that R1 was on thirty minute checks, and had just been found a half a block away. When she walked outside with R1, the WanderGuard alarm did not go off, so RN-A was not aware R1 had a WanderGuard or was at risk for elopement.</p> <p>On 10/3/24 at 3:25 p.m., the Securitas Healthcare (WanderGuard) representative stated the WanderGuard bracelets should be checked daily to ensure each bracelet was working correctly.</p> <p>The WanderGuard manufacture's manual undated, directed staff to test WanderGuard signaling devices daily and record the results in the resident's records.</p> <p>On 10/3/24 at 3:46 p.m., R1's nurse practitioner (NP)-A stated R1 was a vulnerable adult with poor judgement, and could have been hit by a car, fallen, or walked in on coming traffic and gotten hurt.</p> <p>The facility Wander Management System Policy revised 10/2/24, directed that wander management system bracelets are checked weekly for function.</p>	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2024
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F 689	Continued From page 5 The immediate jeopardy began on 9/27/24, was removed on 10/4/24 when the facility reviewed and revised their current policy on WanderGuards. The facility reviewed all residents with WanderGuards to ensure bracelets were working correctly by checking function daily. The facility completed staff education on the WanderGuard policy. This was verified through observation, interview and document review.	F 689		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2024
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NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 10/3/24, 10/4/24 and 10/8/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, Licensure, and the following</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE

10/23/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2024
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2 000	<p>Continued From page 1</p> <p>licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaint was reviewed during the survey: H50639221C (MN00107036) with a licensing order issued at 4658.0520 Subp 1.</p> <p>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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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</p>	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) who was at risk for elopement. This resulted in an immediate jeopardy (IJ) for R1	2 830	Corrected	10/9/24

Minnesota Department of Health

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2 830	<p>Continued From page 3</p> <p>when he eloped from the facility and was found half a block away.</p> <p>The IJ began on 9/27/24 at 4:00 p.m. when therapy director (TD)-A discovered R1 outside of the facility on the sidewalk, approximately half a block from the building. The administrator and director of nursing (DON) were informed of the IJ on 10/3/24 at 4:53 p.m. The IJ was removed on 10/4/24, but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>R1's Face Sheet dated 10/4/24 indicated R1 had diagnoses of Alzheimer's disease, traumatic brain injury, and dementia.</p> <p>R1's significant change Minimum Data Set (MDS) dated 7/31/24 indicated R1 had severe cognitive impairment. The MDS also identified R1 used a wander/elopement alarm daily.</p> <p>R1's Elopement Risk Assessment dated 9/5/24 indicated R1 was at risk for elopement.</p> <p>R1's care plan dated 6/3/24 indicated R1 was at risk for elopement and wandering, and utilized a WanderGuard management system (used to trigger alarms to alert staff when a resident wearing a WanderGuard bracelet is near a door). Interventions indicated WanderGuard was on left wrist, and R1 had wandering safety checks every thirty minutes.</p> <p>R1's Treatment Administration Record dated</p>	2 830		

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2 830	<p>Continued From page 4</p> <p>6/3/24 indicated staff to check WanderGuard placement every shift, check function weekly, and change WanderGuard every 90 days.</p> <p>On 9/27/24 at 6:08 p.m., a progress note written by registered nurse (RN)-D indicated R1 was found ambulating on the sidewalk approximately half a block from the facility, and assisted back to the facility by staff. R1's WanderGuard was checked and replaced.</p> <p>On 10/3/24 at 9:16 a.m., licensed practical nurse (LPN)-A stated she didn't check R1's WanderGuard to ensure it was functioning on 9/24/24, but she charted she had checked it in R1's electronic medical record (EMR) "accidentally." She stated she didn't replace R1's WanderGuard on 9/23/24, but she did chart in R1's EMR it was completed. LPN-A did not offer an explanation as to why she charted she had replaced it, when in fact, she had not.</p> <p>On 10/3/24 at 9:24 a.m., R1 stated he left the facility and they found him on the farm. He stated he does not remember where he was going. He stated he plans on leaving the facility again to go to his wife's house.</p> <p>On 10/3/24 at 11:22 a.m., RN-B stated on 9/27/24 around 3:15 p.m., she saw R1 come off the elevator onto the first floor with RN-A. She told RN-A that R1 was on thirty-minute checks, and asked RN-A to take R1 back to his room. She stated RN-A walked outside with R1, and the alarm didn't go off for R1's WanderGuard. RN-A then went back into the facility a few minutes later and told her (RN-B) R1 was at the patio. RN-B thought RN-A had brought R1 back up to his room.</p>	2 830		

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2 830	<p>Continued From page 5</p> <p>At around 4:00 p.m., therapy director (TD)-A brought R1 back to the facility, and said she had found R1 walking on the sidewalk on Como Avenue. R1's WanderGuard bracelet did not alarm when R1 entered the facility.</p> <p>On 10/3/24 at 12:24 p.m., RN-D stated on 9/27/24 at around 4:10 p.m., TD-A notified her R1 was found on the sidewalk on Como Avenue and was brought back to the facility. She stated R1's WanderGuard was not triggering the alarm system to sound, so RN-D changed R1's WanderGuard at that time.</p> <p>On 10/3/24 at 12:59 p.m., TD-A stated on 9/27/24 around 4:03 p.m., she was driving home from work and spotted R1 on Como Avenue walking toward Commonwealth Street. She turned her car around to pick him up after he crossed Commonwealth Street, and she brought him back to the facility.</p> <p>On 10/3/24 at 1:10 p.m., RN-A stated on 9/27/24 around 3:30 p.m., she got on the elevator and R1 was on the elevator. She walked outside with R1, R1 sat down at a chair in the front patio area, and she went back into the facility. She told RN-B she had to go back upstairs, and asked RN-B to keep an eye on R1. RN-A went back to the second floor. Later that shift, RN-A was told that R1 was on thirty minute checks, and had just been found a half a block away. When she walked outside with R1, the WanderGuard alarm did not go off, so RN-A was not aware R1 had a WanderGuard or was at risk for elopement.</p> <p>On 10/3/24 at 3:25 p.m., the Securitas Healthcare (WanderGuard) representative stated the WanderGuard bracelets should be checked daily</p>	2 830		

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2 830	<p>Continued From page 6</p> <p>to ensure each bracelet was working correctly.</p> <p>The WanderGuard manufacture's manual undated, directed staff to test WanderGuard signaling devices daily and record the results in the resident's records.</p> <p>On 10/3/24 at 3:46 p.m., R1's nurse practitioner (NP)-A stated R1 was a vulnerable adult with poor judgement, and could have been hit by a car, fallen, or walked in on coming traffic and gotten hurt.</p> <p>The facility Wander Management System Policy revised 10/2/24, directed that wander management system bracelets are checked weekly for function.</p> <p>The immediate jeopardy began on 9/27/24, was removed on 10/4/24 when the facility reviewed and revised their current policy on WanderGuards. The facility reviewed all residents with WanderGuards to ensure bracelets were working correctly by checking function daily. The facility completed staff education on the WanderGuard policy. This was verified through observation, interview and document review.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could rview/revise policies and procedures related to residents at risk for elopement. The DON or designee could educate all staff on these policies and pcedures. The DON or designee could complete audits, and bring the results of these audits to the Quality Assessment committee.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 830		

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