Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 11, 2019

Administrator
St Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

RE: Project Number H5267090C

Dear Administrator:

On March 8, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 12, 2019.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on February 21, 2019. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 5, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on February 21, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 22, 2019. We have determined, based on our visit, that your facility has corrected as of March 22, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 12, 2019 be rescinded. (42 CFR 488.417 (b))

In our letter of March 8, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2019, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 22, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

Electronically delivered
March 8, 2019

Administrator
St Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

RE: Project Number H5267090C

Dear Administrator:

On February 21, 2019, an abbreviated standard 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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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 Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy(ies) 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 May 12, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 12, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 12, 2019.

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 $10,483; 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.

If you have not achieved substantial compliance by May 12, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Anthony Health & Rehabilitation will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor

Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 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 August 21, 2019 (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

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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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: 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 electronic 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.

Feel free to contact me if you have questions.

Sincerely,

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING ______ B. WING ______	C 02/21/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted 2/21/19, to investigate complaint H5267090C. St. Anthony Health and Rehabilitation is not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities for F689. 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 §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 supervise and comprehensively assess the elopement risk for 1 of 3 residents (R1) who was identified as an elopement risk	F 689	R1 sent to the hospital and did not return to the facility. R1's 30 day and 60 day MDS modified.	3/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/18/2019

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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F 689	Continued From page 1 upon admission. A wander guard alarm was placed on R1 after admission and the facility failed again to assess R1's elopement risk and identify approaches and interventions. This resulted in actual harm when R1 eloped out of the building on 2/11/19, was brought back into the building approximately 20 minutes after being outside, R1 became unresponsive, went into cardiac arrest, was brought to the hospital and died. Findings include: R1's admission face sheet identified R1 was admitted on 12/12/18, with diagnoses that included cerebral infarction due to embolism of unspecified cerebral artery (stroke), aphasia, muscle weakness and diabetes. R1's admission Minimum Data Set (MDS) dated 12/19/18, identified R1 had severe cognitive impairment needed 2 person extensive assistance with bed mobility, transfers, and locomotion on the unit, the admission MDS identified R1 did not wander. The prospective payment system (PPS) 60 day MDS dated 2/11/19, identified R1 had severe cognitive impairment, was a two person extensive assist for transfers, a one person physical assist with supervision for walking in his room, the corridor and locomotion on and off the unit. The 60 day MDS also indicated R1 wandered daily. The Treatment Administration Record order (TAR) for February 2019 identified R1 had a wander guard (started 1/27/19). Staff were to ensure wander guard was on the left wrist at all times due to cognitive impairment. The clinical admission assessment dated 12/12/18, at 7:13 p.m. revealed R1 had a	F 689	An alarm was immediately (2/12/19) placed on the exit door. All other door alarms were checked and functioning. All other residents at risk for elopement have had their elopement risk assessments and care plan interventions reviewed and revised as needed. Residents will continue to be reviewed for elopement risk with any changes in condition; or with each quarterly, annual, or significant change of condition MDS. All other residents with Roam Alert bracelets have had their MDS reviewed for accuracy with modifications completed as needed. Staff were notified of the new door alarm immediately at the time of the incident via email and all staff daily communication. Nursing Staff were in-serviced on new door alarm and Roam Alert bracelet procedure with return signatures during week of Feb 24-March 1. SS Staff will be re-trained on MDS accuracy. Facility wide in-services will be held on completion of risk assessments, door alarms, and Roam alert system during the week of March 18-22 Maintenance staff will continue to check the door alarms and Roam alert system weekly for functioning. Residents with Roam alert bracelets will be checked daily with placement and functioning. Director of Social Services or designee	

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F 689	Continued From page 2 moderate elopement risk based on the recent move to the facility and had a history of wandering in the last 60 days. Preventative action included: identification band on resident, frequent room checks, social services, family and staff visits. Review of the care plan with effective date of 12/12/18, did not reveal any identification that R1 wandered or was at a moderate risk for elopement. A resident plan of care summary (undated) listed R1 with safety concerns/risks of falls and elopements. Review of clinical notes for R1 included the following: 12/13/18, at 7:25 a.m. R1 admitted on 12/12/18, at 5:00 p.m. R1 identified as impulsive and wandered. Staff kept R1 in the common area to monitor closely until 9:30 p.m. when he was assisted to bed. 12/24/18, at 1:09 p.m. R1 was a high fall risk related to his cognitive impairment regarding safety, impulsivity and lack of safety awareness. New intervention included staff to check on R1 frequently at the beginning of the night shift and through out the shift for safety. Continue to monitor and adjust per R1's needs. 12/30/18, at 6:05 a.m. Staff put R1 to bed and R1 attempted to get out of bed. Staff brought R1 to the common area for close monitoring. Needed to be monitored one to one. Will continue to monitor. 1/3/19, at 8:18 p.m. R1 needed one to one supervision.	F 689	will complete a weekly audit to ensure resident behaviors are accurately documented on the MDS until the next facility QAPI meeting on April 16, 2019 The Director of Nursing will review the completed audits and bring any identified MDS accuracy or Roam alert system concerns to the facility QAPI committee for review and further recommendations. The Executive Director and Director of Nursing remain responsible for compliance with this requirement to ensure residents are supervised.	

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F 689	Continued From page 3 1/5/19, at 2:11 p.m. R1 wandered by the nurses' station and tried to go inside other residents' rooms. 1/5/19, at 5:24 p.m. R1 attempted to enter other residents' rooms, staff was able to re-direct. 1/8/19, at 5:43 a.m. R1 spend the whole night in his wheel chair and slept. Staff attempted to assist R1 to bed and R1 self transferred out of bed. R1 brought back to the nurses' station for close supervision through out the shift. Will continue to assess. 1/12/19, at 1:30 a.m. R1 sat in a wheelchair by the nurses' station for close observation. 1/18/19, at 5:19 a.m. R1 was up in his wheel chair in the common area. R1 slept in the recliner at 12:00 a.m. At 2:00 a.m. R1 wandered the unit and attempted to enter other residents' rooms but was redirected. At 3:00 a.m. R1 grabbed things from the nurses' station, attempted to open locked medication carts and attempted access to locked medication cart computers. Continued to self transfer and attempted to enter other residents' rooms. 1/27/19, at 8:53 p.m. R1 wandered around the unit. Wander guard placed on left wrist to be monitored by staff. 1/28/19, at 5:47 p.m. R1 repeatedly packed and unpacked and rearranged his belongings. Talked about "moving once I get the clearance code." 1/29/19, at 6:38 a.m. R1 paced on the floor and exhibited exit seeking behavior. R1 eloped out of	F 689		

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F 689	Continued From page 4	F 689		

the building at the beginning of the shift. R1 was seen at the exit of the building and was redirected back by staff upon hearing the wander guard alarm activated. Staff will continue to monitor

1/29/19, at 3:14 p.m. R1 was alert and oriented times 2, risk of elopement, had a wander guard on his left wrist. R1 wandered around the unit and looked for an exit, "staff tirelessly kept redirecting." Will continue to monitor.

1/31/19, 10:50 a.m. R1 walked and wandered around the unit early in the morning and packed and unpacked his personal belongings. R1 said, "I am going home." R1 was redirected.

2/2/19, at 10:42 a.m. R1 wandered around the unit and other residents' rooms. R1 was re-directed.

2/3/19, at 10:47 a.m. R1 wandered around the unit and other residents' rooms. R1 was re-directed.

2/4/19, at 9:36 p.m. R1 continued to wander from room to room/other floors and needed continuous staff re-direction and supervision.

2/6/19, at 9:40 p.m. R1 was restless after dinner and picked up items from the nurses' station and other residents' rooms, wandered to other units and wanted to go outside. R1 was not easy to redirect and staff had to stay with him continuously. Later R1 got exhausted and say by the TV area next to the nurses' station. Will continue to monitor and redirect as needed.

2/12/19, at 12:03 a.m. R1 was his normal self this afternoon and ambulated to all places on the unit.

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F 689	Continued From page 5 After dinner R1 paced in the hallway, he tried to open the exit door by the subacute dinning room and the alarm went off. A barrier was placed by the exit and staff supervised his moves. Medications were administered at 7:45 p.m. At 8:05 p.m. R1 was brought back to the receptionist desk by a good Samaritan. According to the receptionist, the person that brought R1 back to the facility found R1 by the apartments across from the facility's parking lot. When R1 was brought back to the facility, he complained of trouble breathing as he walked with staff back to the unit. R1 sat at a couch next to the nurses' station and oxygen was immediately applied at 5 liters(L)/minute using an oxygen concentrator. R1's fingers were very cold and staff was unable to get a saturation level. There was a brief oxygen saturation (levels that measure the degree to which the hemoglobin contained in the red blood cells has bonded with oxygen molecules) reading of 40 (A range of 94-99 is normal) but it immediately went blank. Code blue was paged via the overhead pager to alert staff of the emergency. At 8:10 p.m. 911 called and family was notified of R1's condition. R1's fingers were cold, which made it difficult to read oxygen saturations, warm blankets were placed on resident. R1 started to foam at the mouth and oral suctioning was initiated as paramedics arrived at 8:20 p.m.. R1 was still breathing when the paramedics arrived. R1 became unresponsive and cardiopulmonary resuscitation (CPR) was initiated with paramedics present. At 8:55 p.m. R1 was taken to the hospital. On 2/21/19, at 10:39 registered nurse (RN)-B said a resident needed to be assessed for the placement of a wander guard. If staff notice that a resident has tried to open exit door or wants to	F 689		

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F 689	Continued From page 6	F 689		

go home there is a standing house order for wander guard placement and a nurse can asses a resident has a risk for elopement and place a wander guard on a resident. After a wander guard is placed, nursing staff will check it every shift to make sure that it works and document the check in the Medication Administration Record (MAR). The nurses will inform the nursing assistants as to what residents have a wander guard on.

On 2/21/19, at 11:27 p.m. licensed practical nurse (LPN)-A stated after the incident the facility management had staff go through a flyer about the wanderguard and residents at risk for elopement. LPN-A stated also with the training they were to check the wanderguards on residents to make sure they functioned properly. When asked about the exit door where R1 had gone through, LPN-A stated after the incident a sensor was then installed on the door to alert the staff if someone was opening the door which was not in place before. LPN-A stated she did not think the time frame from the time the sensor went off which was 30 seconds was enough as at times staff was in residents rooms and if staff was not in the common areas they would not be able to respond to it timely. LPN-A further stated R1 was at risk for elopement as at times he would disappear when all the staff was in other residents' rooms and when they came out and did not see him "we had to stop everything to find him."

On 2/21/19, at 11:38 a.m. the director of social services (DSS) said social services would assess a resident's elopement risk quarterly with the MDS, and as needed, and update the care plan to reflect the elopement risk. DSS said when a resident is first admitted there is an initial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING ______ B. WING ______	C 02/21/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 elopement assessment that is connected to the clinical admission evaluation assessment that nursing completes. If there was a change since admission and a resident started to wander as a new behavior, nursing staff would let social services know and an elopement assessment would be completed by social services and the care plan would be updated to reflect the elopement risk. DSS verified the clinical admission evaluation assessment dated 12/12/18, identified R1 as a moderate elopement risk, which should have triggered an assessment and care plan development and there was not an elopement assessment completed or care plan developed. DSS was unable to find an elopement assessment for R1 after the wanderguard was placed on 1/27/19, and was not aware if nursing staff notified social services about the wanderguard placement. On 2/21/19, at 11:42 a.m. anonymous staff stated had not received any training following the elopement incident. Staff stated after the incident when getting report it had been brought up R1 had eloped and was brought back to the facility by a neighbor but had a cardiac arrest and had passed away. Staff indicated on the day of the incident during the morning shift R1 had been exit seeking and had the usual wandering behaviors. Staff also stated during R1's stay at the facility all staff during her shift made sure they all knew the whereabouts of R1, "If we don't see him we have to stop what we are doing to find him and re-direct him back to a common area." On 2/21/19, at 12:01 p.m. the social services assistant (SSA) said that she was aware that a wander guard was placed on R1 on 1/27/19, however, at that time SSA did not know it was the	F 689		

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	245267	A. BUILDING ______ B. WING ______	C 02/21/2019

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

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F 689	Continued From page 8 responsibility of social services to complete the elopement assessment or update the care plan when a wander guard was placed on a resident. On 2/21/19, at 12:10 p.m. nursing assistant (NA)-A stated she had not received any training regarding the wanderguard but she was aware R1 had eloped and was brought back. When asked if she was aware of the anything being installed to the exit door R1 had gone through NA-A stated, "No. The nurses check them." On 2/21/19, at 12:29 p.m. an interview was completed with the director of nursing (DON) and the regional clinical nurse. When asked about the incident, the DON stated the facility staff had called her that evening initially and had stated a neighbor had brought R1 back to the building then the receptionist had the transitional care unit (TCU) nurses to get R1 back to the unit. The DON stated after R1 returned to the unit he was noted with shortness of breath then oxygen was applied and then he became unresponsive and staff nurses initiated cardiopulmonary resuscitation (CPR) as the nurses called 911. The DON stated the staff continued to administer CPR until the paramedics arrived and during that time the nurses had not been able to obtain an oxygen saturation level via the finger probably due to R1 being to cold. The DON stated the nurse assigned to R1 on the evening of the incident had stated he had given R1 his evening medications around 7:45 p.m. and had gone on with the medication pass for other residents until when they were made aware R1 had been brought back to the facility. When asked if the staff was supposed to know R1's whereabouts, the DON stated R1 was not on one to one supervision but the staff had encouraged him to	F 689		

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

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F 689	Continued From page 9	F 689		

stay by the desk so the staff could keep close eye on R1.

When asked why the exit door did not have an alarm like other doors in the building she stated after the incident that was when the facility identified the door never had an alarm to it. The DON stated after the incident then signs were put on the door and a exit alarm which was supposed to be on for 30 seconds after someone exited the door to alert staff and the alarm was loud.

When asked how the staff were notified and trained following the incident, the DON stated an e-mail was sent out to the nurses to alert them. Then other training information was provided to all the staff through the facility training platform "platinum service." In addition, the DON stated the training was usually posted in the break room for staff for four days and after was taken down. When asked how the facility made sure all staff had received the training provided following the incident, the DON stated she did not have a signing sheet or any way of knowing that instead for her she thought she needed to get the information out immediately and thought after the door alarm was installed it was loud to alert staff.

The DON said when R1 first was admitted, he wandered around the unit and then his behavior started to change and R1 said he wanted to leave. Staff put a wander guard on R1 and put it on the treatment sheet to check the wander guard each shift. The DON acknowledged she would have expected an elopement assessment to be completed and a care plan developed upon admission and R1 should have been re-assessed when the wander guard was added and his care plan to be updated.

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F 689	Continued From page 10 The policy for elopement risk (last reviewed 10/30/18) indicated residents would be assessed for elopement risk on admission and throughout their stay by the interdisciplinary team. Under the procedure section staff was directed to observe residents determined to be at risk for elopement or elopement sign and/or attempts and interventions will be included in their comprehensive plan of care to address the potential for elopement. The policy for wander guards (last reviewed 10/30/18) indicated an elopement evaluation is completed upon admission, re-admission, quarterly with the MDS process, when a resident is moved in or out of a memory care and PRN (as needed) when the resident may exhibit a change in condition where they might be a wander risk and have the need for a wander guard alarm.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

April 12, 2019

REVISED LETTER

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

Re: Project Number H5267090C

Revised Letter: This letter revises and replaces the previous State Licensing letter dated March 8, 2019. The previous letter incorrectly stated there were deficiencies issued.

Dear Administrator:

The above facility survey was completed on February 21, 2019 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

Electronically delivered
March 8, 2019

Administrator
St Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

Re: State Nursing Home Licensing Orders - Project Number H5267090C

Dear Administrator:

The above facility was surveyed on February 21, 2019 through February 21, 2019 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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 **02/21/2019**

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

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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: On 2/21/19, surveyors of this Department's staff visited the above provider for a complaint investigation to investigate complaint H5267090C . No correction orders were issued The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/19

Minnesota Department of Health

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 **02/21/2019**

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

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2 000	Continued From page 1 not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		