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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Park Home Inc	2237 Commonwealth Avenue Saint Paul, MN 55108

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790 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. 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. Findings include: R1's Face Sheet dated 10/4/24 indicated R1 had diagnoses of Alzheimer's disease, traumatic brain injury, and dementia. R1's significant change Minimum Data Set (MDS) dated [DATE] indicated R1 had severe cognitive impairment. The MDS also identified R1 used a wander/elopement alarm daily. R1's Elopement Risk assessment dated [DATE] indicated R1 was at risk for elopement. 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. 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. 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. (continued on next page)

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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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. 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. 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 [NAME] Avenue. R1's WanderGuard bracelet did not alarm when R1 entered the facility. 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 [NAME] 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. 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 [NAME] 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. 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. 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. The WanderGuard manufacture's manual undated, directed staff to test WanderGuard signaling devices daily and record the results in the resident's records. 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. The facility Wander Management System Policy revised 10/2/24, directed that wander management system bracelets are checked weekly for function. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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.