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	08/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure resident's needs were addressed in a respectful and dignified manner when a resident (R34) used a call light for help. Additionally, the facility failed to ensure all staff knock on individual resident bedroom doors and introduce themselves prior to entry for 3 residents (R68, R76, R74). Furthermore, the facility failed to provide a dignified dining experience for 3 residents (R21, R31, R68). Findings include: Call Lights R34's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of hemiplegia (one-side paralysis) and hemiparesis (weakness or the inability to move on one side of the body) after a stroke and high blood pressure. R34's care plan dated 8/30/23, indicated he was dependent on staff/volunteers/family for meeting his emotional, intellectual, physical, and social needs related to his tendency to not seek out activities. The care plan also identified R34's activities of daily living (ADL) self-care needs related to his left-sided weakness, including an assist of one staff person to transfer with an EZ stand medium harness. During continuous observation on 8/6/24 between 12:51 p.m. and 1:24 p.m., two call lights were on in the same hallway with an alarm sounding. - At 12:55 p.m., R34's call light was noted to be on as indicated by the light on above his door, however the alarm was not sounding. - At 12:58 p.m., registered nurses (RN)-D and RN-F were standing in front of the medication carts in the dining area when R34 was heard calling, hello from his room. - At 12:59 p.m., nursing assistant (NA)-C exited a room in the same hallway as R34's room with meal trays in hand and walked towards the dining area. RN-F walked towards R34's room but turned and knocked to go into a different room to assist another resident. (continued on next page)

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

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	08/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 1:00 p.m., RN-D approached the room where the first call light was observed to be on, knocked and entered the room and turned the call light off. - At 1:01 p.m., RN-D exited the room with a meal tray. R34's call light remained unchanged. - At 1:02 p.m., the assistant director of nursing (ADON) walked out from behind the nurse's station, into the dining area and down the hallway where R34's room was. The ADON turned into the tub/shower room. R34's call light remained unchanged. - At 1:03 p.m., RN-D was standing at the medication cart in the dining room. - At 1:05 p.m., NA-B walked down the hallway and into the room RN-F was in. - At 1:07 p.m., the call light alarm box at the nurse's station displayed the text, W226 NORMAL and was alarming with sound. It did not display a duration the call light had been on for. - At 1:08 p.m., RN-F exited the room and walked away from R34's and into the dining area. - At 1:11 p.m., RN-F walked down the hallway towards R34's room and entered another resident's room without a call light on. - At 1:12 p.m., RN-F exited the room and performed hand hygiene. RN-F walked down the hallway towards R34's room and entered a different resident's room without a call light on. RN-D was standing at the medication cart in the dining area. - At 1:13 p.m., RN-F exited the room with the resident and walked to the dining area. RN-F performed hand hygiene at the medication cart. R34's call light remained unchanged. - At 1:14 p.m., R34 stated in an interview he turned his call light on at 12:51 p.m. because he wanted to transfer into his recliner. He stated he needed staff assistance and the EZ Stand to transfer. R34 stated he experienced long call light wait times most of the time and stated, it's getting old. - At 1:18 p.m., RN-F walked down the hallway with a medication cup in hand towards R34's room. RN-F entered another resident's room that had a call light on. - At 1:19 p.m., RN-F exited the room and walked down the hallway towards the dining area. R34's call light remained unchanged. - At 1:21 p.m., NA-C walked down the hallway with another unidentified resident and entered a different room. - At 1:22 p.m., NA-C stopped into a room with a call light on near R34's room. - At 1:23 p.m., NA-C answered R34's call light request. - At 1:28 p.m., NA-C pushed R34 down the hallway in his wheelchair and into the tub/shower room. (continued on next page)

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	08/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 8/6/24 at 1:37 p.m., RN-D stated the goal is to keep the call light wait time under 20 minutes but understood that a lot of residents required two staff for assistance. RN-D verified waiting 30 minutes was pushing it and stated the floor was pretty full census wise so it could be a strain. During interview on 8/6/24 at 3:04 p.m., the ADON stated, I do expect there would be someone to answer the call light, even if you can't help them, to acknowledge them and see what they need. The ADON confirmed 30 minutes was too extended and expected the call light to be answered sooner. The ADON expected any staff, from activities to housekeeping to all my nursing staff, to address a call light if passing by. The ADON stated the risks of not answering a call light in a timely manner included the risk of incontinence, bowel incontinence, and a potential for unsafe self-transfers, although the ADON didn't believe R34 would attempt to self-transfer. During interview on 8/7/24 at 11:52 a.m., the director of nursing (DON) stated it was disappointing to hear about a call light being on for 30 minutes and stated the expectation was for it to be answered in a reasonable time and suggested 10 minutes as a reasonable time. The DON stated the facility attempts to staff up during the day shift to accommodate resident needs. The DON verified concern for dignity with the extended call light wait time and expected all staff, including nurses, to answer call lights. A facility policy titled Answer the Call Light dated 10/18/22, indicated its purpose was to ensure timely responses to the resident's requests and needs. The policy guided staff to answer the resident call system immediately. A facility policy titled Dignity dated 12/8/21, indicated each resident should be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feels of self-worth and self-esteem. The policy indicated residents were treated with dignity and respect at all times and the facility culture supported dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. 49339 Dignified Dining R31's significant change Minimum Data Set (MDS) assessment, dated 4/23/24, indicated R31 had severely impaired cognition with no hallucinations, or delusions. Further indicated R31 was dependent on staff for all activities of daily living (ADLs) including eating. R21's quarterly MDS assessment, dated 6/11/24, indicated R21 had severely impaired cognition with no hallucinations, or delusions. Further indicated R21 was dependent on staff for all activities of daily living (ADLs) including eating. R68's quarterly MDS assessment, dated 7/15/24, indicated R68 had severely impaired cognition with no hallucinations or delusions. Further indicated R68 was dependent on staff for all activities of daily living (ADLs) including eating. (continued on next page)

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	08/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/06/24 at 8:42 a.m., a table of three residents were seated in wheelchairs at a table. One resident was sitting with her eyes closed with an almost empty plate of food in front of her. The second resident was being assisted by a staff member to eat. R31 was the third resident at the table. Directly in front of R31, on the table, sat a hard plastic tray that contained on it, a warming plate with a cover, bowl with a plastic cover along with covered drinks. R31 was intermittently yelling out which caused other residents to look over at her. R31 continued to sit at the table with a clothes protector on with the covered food tray in front of her. No staff were interacting with R31. At 8:56 a.m., staff sat next to R31, uncovered the food in front of her and started to feed her (14 minutes after observation started). R31's food was left on the hard plastic tray during the meal. R31 stopped yelling out when staff started to assist her with her breakfast. During observation on 8/6/24 at 12:18 p.m., two lunch carts were brought to 2nd floor and delivered to the 2nd floor dining room by unknown dietary staff. Each lunch cart was an enclosed metal cart on wheels with slots, that held hard plastic trays that contained resident meals. Each slot could hold two hard plastic trays which could be slid from the front or back of the approximately 6-foot metal cart. The hard plastic trays each contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The tray contained a set of silverware along with a napkin. Staff would grab the trays from the lunch cart, add the drinks that were requested from a different cart and deliver the entire tray to residents sitting at the table. Staff would leave the food and drinks on the hard plastic tray that contained the entire meal including the drinks and silverware. At 12:22 p.m., R31, R21 and R68 were observed to be seated at the same table. R31 and R21's lunch trays were set in front of them (just the way trays sent up from the kitchen). At 12:23 p.m., R68's tray was set in front of him. Staff proceed to get drinks for all the trays and set them in front of R31, R21 and R68 on the hard plastic trays. At 12:30 p.m., staff sat next to R31 to assist her to eat. At 12:35 p.m., a second staff sat next to R68 to assist him to eat (13 minutes after the food had been placed in front of him). At 12:38 p.m. a third staff sat next to R21 to assist her to eat (16 minutes after her food had been sitting in front her). R21, R31 and R68 were non-interviewable as unable to answer questions. During an interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated meal trays are not handed out in a certain order, and we just make sure residents get the right tray. NA-C verified they do not take food off the hard plastic trays to serve the residents. NA-C verified that some residents must wait to be assisted with their meals. (continued on next page)

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	08/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/06/24 at 2:14 p.m., NA-B stated that each staff passes out their own resident trays. NA-B stated that after all the trays are handed out to residents then they assist residents who need help. NA-B verified that residents may have to wait a little while for assistance with their meals as they have other to help and must pass out other trays. NA-B verified the plates and drinks are not removed from the plastic trays when they are served to residents as it makes serving easier. During an interview on 8/07/24 at 11:09 a.m., NA-D stated that residents in the dining room are served first, then room trays are delivered and then residents who need assistance are assisted. NA-D stated all meals are served on the hard plastic trays to residents and have always done that, adding it makes it easier to clean up. During an interview on 8/07/24 at 11:18 a.m., registered nurse (RN)-C stated that meal trays are not served in any order but we try to serve independent people first, then those who need supervision and then those who we assist last. RN-C stated there is no assigned seating in the dining room but try to have resident who need supervision or assistance sit together. RN-C stated, trays are left underneath the meals. On 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated meal trays are not served in a certain order and there is no assigned seating. ADON verified that meals are served to residents on the hard plastic trays (food items are not removed and placed directly on the table) stating, there is not a reason why we do that It is easier to carry. On 8/07/2024 at 2:11 p.m., director of nursing (DON) verified there is no specific reason that meals are served on hard plastic trays to residents. DON stated residents should be served meals at the same time and staff should be able to assist when meals are served. NOT KNOCKING ON RESIDENTS' DOOR PRIOR TO ENTERING R68's quarterly MDS assessment, dated 7/15/24, indicated R68 had severely impaired cognition with no hallucinations or delusions with an admitted [DATE]. R76's admission MDS assessment, dated 6/24/24, indicated R76 has moderately impaired cognition with no hallucinations or delusions with an admitted [DATE]. R74's admission MDS assessment, dated 6/7/24, indicated R74 had severely impaired cognition with no hallucinations or delusions with an admitted [DATE]. During observation on 8/06/24 between 10:30 a.m. and 10:55 a.m., nursing assistant (NA)-B entering R68's room numerous times without knocking or announcing self. NA-B was also observed entering R76's room, during that time, without knocking, announcing self, or talking with R76 prior to entering room. (continued on next page)

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	08/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview at 8/6/24 at 11:01 a.m., NA-B verified that they entered R68's numerous times within the last 30 minutes without knocking or announcing self. R68 stated, I am very busy but should've knocked. NA-B couldn't count how many times she had been in and out of R68's room without knocking but stating, a lot. NA-B verified they entered R76 room without knocking as she could see me in the hallway, and I was talking to her. NA-B verified they should always knock before entering a resident's room as it is a privacy and dignity thing to knock on a door prior to entering rooms. On 8/07/24 at 10:10 a.m., housekeeper (HSK)-A was observed opening R74's room door and entering R74's room without knocking or announcing self. On 8/7/24 at 10:12 a.m., HSK-A verified they had delivered soap to R74's room. HSK-A verified they had not knocked or announce themselves prior to opening R74's door and entering room. HSK-A stated, I thought they were sleeping. HSK-A further indicated, you should always knock because you are entering their room. On 8/07/24 at 10:14 a.m., R74 was observed to be lying in bed. R74 answered questions mumbled and non-sensical. On 8/07/24 at 10:16 a.m., R68 did not respond when asked questions. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated it is expected to knock prior to entering a resident's room and should be done all the time. ADON stated, we should treat everyone like humans .we a lot of people have dementia, and we don't want to scare them .it's just the right thing to do. During interview on 8/07/2024 at 2:11 p.m., with director of nursing (DON) stated it is expected that staff either knock or announce themselves by saying hello announce. DON stated this is for dignity and alert them so don't startle them. A facility policy titled Dignity, dated 12/8/21, indicated residents are treated with dignity and respect at all times. Further indicated, residents are provided with a dignified dining experience.

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	08/07/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on interview and document review, the facility failed to ensure allegations of potential abuse were reported in a timely manner to the state agency (SA) for 1 of 1 residents (R21) whose allegations were reviewed. Findings include: R21's quarterly Minimum Data Set (MDS) dated [DATE], identified R21 had severely impaired cognition with no hallucinations or delusions, and was dependent on staff for all activities of daily living (ADLs) including bed mobility and transfers. R21's care plan, printed 8/7/24, identified R21 transferred with a Hoyer (mechanical lift) and assist of 2 staff. In addition, R21 was unable to adequately verbalize her needs, Speech is nonsensical, disorganized and unintelligible when she speaks. Furthermore, the care plan identified, my safety is at risk and there is potential for abuse due to: Cognitive Impairment, Dementia, or poor decision making. R21's progress note dated 8/1/24, identified the following entry: Residents son flagged writer to come to his mom's room He said there's a bruise here, has anyone reported it, it's probably from the Hoyer but I wanted you to see it. He showed me a very faint discoloration on L chest below her breast. Will monitor. R21's progress notes from 8/1/24 to 8/7/24 reviewed and lacked evidence of any other progress notes monitoring bruise mentioned. A Skin and Wound Evaluation, dated 8/5/24, identified a bruise on left chest. Exact date of bruise was noted as 8/1/24 and area was measured as followed: Area: 35.0 cm (centimeters)2[squared] Length: 9.3 cm Width: 5.9 cm: A section on the bottom of the assessment indicated, son reported faded bruise on left chest. Will continue to monitor. Notifications completed: a radio-button answered: resident/responsible party notified. During an interview on 8/06/24 at 3:07 p.m., family member (FM)-A stated he reported the bruise on R21's chest to the nurse on 8/1/24. FM-A stated they are concerned that staff aren't gentle and if I don't advocate for her, she will be neglected. FM-A stated the bruise on R21's chest was reported to FM-A from the hospice nurse on 7/31/24 and stated that no staff from the facility reported the bruise to FM-A. FM-A stated, I get really worried as staff isn't equipped to handle this population, they aren't trained, they bring in agency staff who don't know anyone and don't care, they just flop them around and not gentle. (continued on next page)

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	08/07/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's medical record was reviewed and lacked any evidence the allegation of potential abuse or neglect had been reported to the State Agency (SA). During interview on 8/07/24 at 11:18 a.m., registered nurse (RN)-C indicated that a bruise with unknown origin would be entered into the risk management section of the electronic medical record (EMR). RN-C verified R21's bruise was not entered into the risk management section of the (EMR). RN-C verified the provider should be notified of all injuries of unknown origin and that had not occurred with R21's bruise. RN-C verified R21's bruise was not being monitored in the skin/wound tab section and verified that is the other area that it may be monitored. RN-C verified the EMR lacked evidence of monitoring R21's bruise. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) verified that she along with other leadership are responsible for filing reports to the state. ADON verified that she did not assess R21's bruise and did not know if it was a reportable event. During an interview on 8/07/2024 at 2:11 p.m., director of nursing (DON) verified she was aware of the R21's bruise on 8/5/24 after the wound care nurse took a picture of it. DON verified the bruise was not reported to the SA despite it being of unknown origin the location of the bruise being under the resident's breast. DON verified she has not assessed the bruise and the bruise was not assessed by the wound care nurse until 5 days after the entry of the progress note on 8/1/24. DON verified that a bruise could lighten and shrink in size significantly in that time frame. DON stated, the bruise might have been caused by the Hoyer. DON verified, after review, that R21's bruise should have been reported to SA and investigated to determine the cause. A policy titled Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating, dated 3/22/23, was provided. Document indicated, All reports of resident abuse (including injuries of unkonwn origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and throroughly investigated by facility management.

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	08/07/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and record review the facility failed to ensure routine personal care (i.e., incontinent cares, nail care) were provided for 2 of 3 residents (R6, R31) reviewed for dependent activities of daily living (ADL's). Findings include: R6 R6's significant change Minimum Data Set (MDS), dated [DATE], identified R6 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS outlined R6 was dependent on staff for most personal hygiene needs and was not diabetic. On 8/5/24 at 1:47 p.m., R6 was observed seated in a recliner chair while in his room. R6 had long fingernails present on both hands, with the nail edge both having a dark-colored debris present and being several millimeters (mm) long on multiple nails. R6 was questioned on his nail care and who, if anyone, helps him with it. R6 looked at his nails and expressed aloud, My nails need to be clipped. R6 stated he used to clip them himself, however, had lost the clippers awhile back. R6 stated the staff helped him with showers on a weekly basis but nobody from the care center, to his recall, had asked him about clipping his nails in the past few weeks. R6's care plan, dated 7/2024, identified R6 had an ADL self-care deficit due to post-polio syndrome and impaired mentation. The care plan directed, PERSONAL HYGIENE/ORAL CARE: Requires assistance of 1. The care plan lacked any information on nail care (i.e., preferred length, clipping frequency). On 8/6/24 at 9:40 a.m., R6 was observed again seated in his recliner chair. R6's fingernails remained long and soiled as had been observed the day prior. R6's Weekly Skin Review Assessment, dated 8/3/24, identified R6 had no skin issues along with dictation, [R6] had shower. skin check completed with no new skin issue noted. The completed evaluation lacked evidence if nail care had been offered, provided or refused. Further, R6's medical record, including progress notes, lacked evidence nail care had been done, offered or refused within the last week despite R6 having long, potentially soiled nails present. When interviewed on 8/6/24 at 10:02 a.m., nursing assistant (NA)-F stated they had worked with R6 multiple times prior and described him as needing total help with cares and hygiene. NA-F stated R6 rarely, if ever, refused care and the NA's would be responsible to help him complete nail care with his showers. NA-F stated if nail care was refused, then the nurse should be told and they likely charted it but the NA charting didn't have spacing to record such. At 10:06 a.m., NA-F observed R6's nails while licensed practical nurse (LPN)-B was present in the room helping R6's roommate. NA-F verified R6's nails were long adding, They need to be trimmed and cleaned. NA-F stated it looked as it had been awhile since nail care was last done and verified R6 was unable to clip his own adding, He's total [care] and we have to do everything for him. NA-F stated they had never seen or heard of R6 having his own clippers before. (continued on next page)

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	08/07/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 at 10:20 a.m., LPN-B was interviewed. LPN-B was questioned on R6's fingernails adding aloud, I noticed that [just prior]. LPN-B stated the nails appeared like they'd been cut and expressed, I will cut them. LPN-B stated nail care, including cleaning and clipping, should be done on scheduled bath days adding the care center had recently switched to a new form (i.e., Weekly Skin Review) which not longer asked about nail care so it was maybe being missed by staff. LPN-B verified R6's nail length and condition adding, That is the longest I've seen them. LPN-B stated R6's nails grow fast and the length of them appeared it had been well over a week since they were last clipped. LPN-B stated R6 was not a diabetic and the NA could help him with clipping, too, if needed. Further, LPN-B stated there was no current place to record nail care being done or offered, but they verified nail care should be completed regularly as long nails could break off, create injury, or promote infection. When interviewed on 8/6/24 at 11:32 a.m., registered nurse (RN)-E stated the care center had recently changed with UDAs [assessments] and no longer had nail care recorded on the weekly skin review. However, RN-E stated nail care should be completed with bathing adding, That's always been the expectation. RN-E stated if nail care was refused, then the nurse should record such in the progress notes after re-approaching the resident; however, RN-E verified the medical record lacked evidence of such. RN-E stated nails should be clipped and kept clean so R6 didn't hurt himself or others with them. A provided Fingernails/Toenails, Care Of policy, dated 2022, identified nail care included daily cleaning and regular trimming adding, Proper nail care can aid in the prevention of skin problems around the nail bed. The policy directed nail care should be recorded in the medical record, including if offered and refused. 49339 R31 R31's quarterly Minimum Data Set (MDS), dated [DATE], indicated R31 had severely impaired cognition with no hallucinations or delusions. Diagnoses included: dementia (loss of memory, language, problem,-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, depression, other frontotemporal neurocognitive disorder (progressive disease of the brain involving frontal and temporal lobes of the brain; can also be referred to as frontotemporal dementia), and polyosteoarthritis (type of arthritis that involves five or more joints at the same time). In addition, R31 was dependent on staff for all ADLs including bed mobility and all hygiene needs. In section H: Bladder and Bowel: section H0300 Urinary Continence: R31 was coded as Always incontinent (no episodes of continent voiding), and in section H0400: Bowel Continence: R31 was coded as Always incontinent (no episodes of continent bowel movements). R31's care plan, printed 8/6/24, indicated R31 has functional bladder and blower incontinent r/t [related to] severe cognitive impairment d/t [due to] dx [diagnosis] of Frontotemporal Dementia with the following interventions: - BRIEF USE: The resident uses disposable XL yellow briefs, Change per schedule and prn [as needed]. (continued on next page)

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	08/07/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- INCONTINENT: Check/change 2-3 hours and as required for incontinent. Wash, rinse and dry perineum. Change clothing PRN after incontinent episodes. Care plan further indicated, ADL self-care needs total assist of one secondary to advanced dementia with the following interventions: - PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (1) staff for personal hygiene and oral care. - TOILET USE: The resident is not toileted. Dignity protocol every 2-3 hours. R31's progress notes, dated 7/9/24 to 8/7/24, were reviewed. Progress notes lacked evidence of R31 refusing staff assistance or documentation of any behaviors. R31's Kardex, printed 8/7/24, indicated R31 required assistance of 1-2 [staff] for bed mobility and to be repositioned every 2-3 hours. Furthermore, the document identified R31 as Incontinent: Check/change 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. During continual observation on 8/06/24: -8:42 a.m., R31 was observed to be seated at the dining room table in her wheelchair, facing the television with two other residents at the table with her breakfast tray in front of her. -8:56 a.m., R31 was assisted with her breakfast -9:34 a.m., R31 continues to sit in the dining room in the same position and a group activity was starting. -10:23 a.m., R31 continues to sit in her wheelchair in the same spot she had breakfast in. R31 has not moved from the location. -11:15 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -11:39 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -12:15 p.m., R31 continues to be seated in her wheelchair in the same position, in the same location she has been in since observation began. -12:22 p.m., R31's meal is placed in front of her on the table. -12:30 p.m., staff sit next to R31 to assist with her meal. -1:54 p.m., R31 remains seated in the dining room, has not been repositioned or brought back to her room. (continued on next page)

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	08/07/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2:14 p.m., R31 remains in the dining room. R31 has been in the same location, in the same position (5 hours 32 minutes after observation began). -3:06 p.m., R31 was observed lying in bed. During interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated the expectation is to check and change a resident that is incontinent is every 2 hours along with repositioning them. NA-C verified they have not repositioned or changed R31 since this morning before breakfast. NA-C verified this was over two hours. NA-C stated, I haven't had a chance because I have a lot of work to do. We are short staffed. NA-C stated they were going to work on it now and verified they are working with R31 today. During interview on 8/06/24 at 2:14 p.m., NA-B stated it is expected to reposition, check and change any resident that is incontinent every 2 hours. NA-B stated they helped transfer R31 this morning prior to breakfast. NA-B stated they have not assisted R31 with any cares, repositioning, or transfers since before breakfast. During interview on 8/06/24 at 3:36 p.m., NA-C stated that after talking with surveyor they brought R31 to their room, transferred her to bed and provided incontinent cares. NA-C verified that R31 had been incontinent of urine and a small amount of bowel movement. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated the expectation is residents who are incontinent of bowel and bladder need to be checked and changed every 2-3 hours along with repositioned. ADON stated, it would be based on the residents care plan. During interview on 8/07/2024 at 2:11 p.m., director of nursing (DON) stated the expectation for residents who are incontinent is they are checked and changed every 2-3 hours or what the care plan says. DON stated it is important to do to offload residents to reduce pressure and to ensure they are clean and dry. A policy titled Activities of Daily Living (ADLs), Supporting, dated 12/7/21, indicated, residents who are unable to carry out activities of daily livening independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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	08/07/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview, and document review the facility failed to ensure assessed and care-planned interventions for preventative skin care were consistently implemented for 1 of 1 residents (R31) reviewed for pressure ulcers. Findings include: R31's quarterly Minimum Data Set (MDS) dated [DATE], indicated R31 had severely impaired cognition with no hallucinations or delusions. Diagnoses included: dementia (loss of memory, language, problem,-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, depression, other frontotemporal neurocognitive disorder (progressive disease of the brain involving frontal and temporal lobes of the brain; can also be referred to as frontotemporal dementia), and polyosteoarthritis (type of arthritis that involves five or more joints at the same time). In addition, R31 was dependent on staff for all ADLs including bed mobility and all hygiene needs. In section H: Bladder and Bowel: section H0300 Urinary Continence: R31 was coded as Always incontinent (no episodes of continent voiding), and in section H0400: Bowel Continence: R31 was coded as Always incontinent (no episodes of continent bowel movements). In Section M: Skin Condition: M0150 risk of pressure ulcers: R31 was identified at risk for developing pressure ulcers. R31's care plan, printed 8/6/24, indicated R31 has potential impairment to skin integrity r/t [related to] incontinence, immobility, impaired cognition, and history of pressure ulcer right heal, with the following interventions: -reposition q[every] 2-3 hrs [hours] R31's care plan further indicated R21 has functional bladder and blower incontinent r/t [related to] severe cognitive impairment d/t [due to] dx [diagnosis] of Frontotemporal Dementia with the following interventions: - BRIEF USE: The resident uses disposable XL yellow briefs, Change per schedule and prn [as needed]. - INCONTINENT: Check/change 2-3 hours and as required for incontinent. Wash, rinse and dry perineum. Change clothing PRN after incontinent episodes. Care plan further indicated, ADL self-care needs total assist of one secondary to advanced dementia with the following interventions: - PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (1) staff for personal hygiene and oral care. -TOILET USE: The resident is not toileted. Dignity protocol every 2-3 hours. R31's progress notes, dated 7/9/24 to 8/7/24, were reviewed. Progress notes lacked evidence of R31 refusing staff assistance or documentation of any behaviors. (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's Kardex, printed 8/7/24, indicated R31 required assistance of 1-2 [staff] for bed mobility and to be repositioned every 2-3 hours. Furthermore, document identified R31 as Incontinent: Check/change 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. During continual observation on 8/06/24: -8:42 a.m., R31 was observed to be seated at the dining room table in her wheelchair, facing the television with two other residents at the table with her breakfast tray in front of her. -8:56 a.m., R31 was assisted with her breakfast -9:34 a.m., R31 continues to sit in the dining room in the same position and a group activity was starting. -10:23 a.m., R31 continues to sit in her wheelchair in the same spot she had breakfast in. R31 has not moved from the location. -11:15 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -11:39 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -12:15 p.m., R31 continues to be seated in her wheelchair in the same position, in the same location she has been in since observation began. -12:22 p.m., R31's meal is placed in front of her on the table. -12:30 p.m., staff sit next to R31 to assist with her meal. -1:54 p.m., R31 remains seated in the dining room, has not been repositioned or brought back to her room. -2:14 p.m., R31 remains in the dining room. R31 has been in the same location, in the same position (5 hours 32 minutes after observation began). -3:06 p.m., R31 was observed lying in bed. During interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated the expectation is to check and change a resident that is incontinent is every 2 hours along with reposition them. NA-C verified they have not repositioned or changed R31 since this morning before breakfast. NA-C verified this over two hours. NA-C stated, I haven't had a chance because I have a lot of work to do. We are short staffed. NA-C stated they were going to work on it now and verified they are working with R31 today. (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/06/24 at 2:14 p.m., NA-B stated it is expected to reposition, and check and change any resident that is incontinent every 2 hours. NA-B stated they helped transfer R31 this morning prior to breakfast. NA-B stated they have not assisted R31 with any cares, repositioning, or transfers since before breakfast. During interview on 8/06/24 at 3:36 p.m., NA-C stated that after talking with surveyor they brought R31 to their room, transferred her to bed and provided incontinent cares. NA-C verified that R31 had been incontinent of urine and a small amount of bowel movement. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated the expectation is residents who are incontinent of bowel and bladder need to be checked and changed every 2-3 hours along with repositioned. ADON stated, it would be based on the residents care plan. During interview on 8/07/2024 at 2:11 p.m., director of nursing (DON) stated the expectation for residents who need to be repositioned and are incontinent is they are checked and changed every 2-3 hours or what the care plan says. DON stated it is important to do to offload residents to reduce pressure and to ensure they are clean and dry. A policy titled Prevention of Pressure Injuries, dated 9/29/21, indicated reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team.

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	08/07/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	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** 33925 Based on observation, interview and document review, the facility failed to ensure behaviors of potential wandering were comprehensively assessed and, if needed, interventions placed to ensure safety and prevent elopement for 1 of 1 residents (R330); and failed to ensure fall interventions were implemented to prevent fall and injury for 1 of 3 residents (R64) reviewed for falls and accidents. Findings include: R330 R330's Nurse Admission/Readmission 05212021 - V15, dated 7/31/24, identified R330 admitted to the care center from the hospital. R330 was recorded as being alert to person and time, however, not to place or aware of her clinical situation with an option being checked, Short term memory loss. The evaluation concluded with a section labeled, Admission Summary, which outlined, . alert and oriented X2 with forgetfulness . assist of one with cares . On 8/5/24 at 2:35 p.m., R330 was observed lying on her bed while in her room which was at the end of a hallway next to a stairwell. R330 smiled at the surveyor upon entrance to the room and expressed aloud, You remember me?! R330 added, I'm your first cousin! R330 stated she had been at the care center just a few days. R330 had flip-flop style shoes in place on her feet, however, did not have any visible wanderguard devices (alerts when attempting to leave an area or building) on her person. Immediately following, at 2:39 p. m., registered nurse (RN)-B was interviewed and stated R6 was very confused. RN-B stated R6 could fool you for awhile but had impaired cognition adding it had been like that since she admitted . R330's initial Elopement Risk Evaluation - V2, dated 8/2/24, identified R330 was non-ambulatory or able to self propel her wheelchair, did not have a history of exit-seeking, and had not eloped or attempted to elope from the facility since the previous observation. The option to select which read, 3. Resident is a new admit, was left unchecked. The evaluation determined R330 was at low-risk for elopement and listed spacing to record what, if any, interventions were implemented including a personal safety alarm, exit alarm, or visual barriers. However, these were all left unchecked. The evaluated concluded, Was the care plan: Initiated [marked]. However, R330's progress note, dated 8/3/24 at 2:03 p.m., identified R330 was seen wandering on another floor looking for the bathroom. The note outlined, During breakfast, Staff was unable to locate resident on her floor and found resident on the first floor, towards the front entrance, sitting on the cough [sic]. It appears as if resident did not remember how to get back to her floor. Resident was redirected. The note lacked what, if any, interventions to reduce the risk of wandering and/or subsequent potential elopement were placed or offered. (continued on next page)

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	08/07/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 8/6/24 at 9:52 a.m., nursing assistant (NA)-G stated they had worked with R330 the evening prior and was again assigned to her care for the current shift. NA-G stated R330 was ambulatory but only walking mostly with therapy and rarely, if ever, found to be self-transferring. NA-G stated they were not really sure if R330 used or wanderguard-type device or if she'd been wandering since admission adding, I worked with her only once. R330's care plan, dated 8/2/24, identified R330 was at low risk for elopement/wandering and listed a goal, The resident's safety will be maintained through the review date, along with a single intervention which read, Assess elopement status quarterly and as needed. The care plan lacked evidence or intervention after being found on another unit near the entrance (progress note, dated 8/3/24). Further, R330's medical record was reviewed and lacked evidence R330 had been comprehensively reassessed for wandering or a potential elopement risk despite being found on a different floor near the exit of the building. When interviewed on 8/6/24 at 10:13 a.m., licensed practical nurse (LPN)-B explained they were currently assigned care for R330 but had also worked with her prior since she admitted a week or so prior. LPN-B verified R330 had cognitive impairment and stated she needed help with transfers and could move with some assistance needed. LPN-B stated they were unaware of any wandering episodes for R330, and explained any re-evaluation of their wandering risk would be according to how alert and oriented they [resident] are. LPN-B stated they felt R330, if found to be wandering at some point, would likely need a wanderguard adding, I would think she would need one. LPN-B stated this was due to R330 not always knowing where she was and being 'forgetful.' Further, LPN-B stated any re-assessment of the need for a wanderguard or similar intervention would be done by the nurse manager or director of nursing (DON) adding, [They] can do their little assessment and say yay or nay. On 8/6/24 at 11:27 a.m., registered nurse manager (RN)-E was interviewed, and verified they had reviewed R330's medical record. RN-E stated the IDT was aware of R330's episode of being found on the first floor and had verbally discussed it, however, felt since it was not actually 'exit-seeking' that a wanderguard wasn't needed. However, RN-E stated the floor staff were going to repeat the elopement screening tool as R330 was now more ambulatory, and they verified the record lacked any re-evaluation despite R330 being found by an entrance on another floor days prior. RN-E stated if staff see behaviors of exit-seeking or wandering, then it should be reported and it was important to do an evaluation so staff is aware and it's communicated and her [R330] safety is maintained. A provided Resident Elopement policy, dated 6/2022, identified staff should report any resident who attempts to leave the premises or is missing. The policy outlined procedures to follow when a resident including upon a resident return (if discovered as missing) which included, Apply a wander guard bracelet with MD order as needed, and, Document relevant information in the resident's medical record. However, the policy lacked information on how wandering, including with potential to elope, would be evaluated or assessed and care-planned (i.e., frequency, person responsible). 49034 R64 (continued on next page)

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	08/07/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	R64's significant change MDS dated [DATE], indicated R64 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R64 was diagnosed with dementia, kidney disease, and diabetes. The MDS indicated R64 used a walker as a mobility device and was independent with transferring and walking. R64's care plan dated 5/3/24, indicated R64 was a high risk for falls related to impulsivity and a history of falls. The care plan indicated staff were to anticipate and meet R64's needs and R64 needed prompt responses to all requests for assistance. The care plan indicated R64 required the assistance of one staff member with ambulation and used a walker. The care plan did not include R64's need for reminders to use his walker. R64's incident report dated 7/19/24 at 11:57 p.m., indicated R64 had an unwitnessed fall and R64 reported that he was unable to grab his walker because it was too far from him. The report included a predisposing situation factors section with using a walker selected. The report indicated immediate action taken was assessing R64's vital signs and assisting R64 back to bed. The report did not include what fall interventions were newly attempted to prevent further falls based on a root cause analysis of the fall. R64's medical record was reviewed and did not include what if any, new fall interventions were attempted after the fall on 7/19/24 based on a root cause analysis. During an observation on 8/6/24 at 9:13 a.m., R64 was observed walking in his room, barefoot, with no walker. NA-B was observed in the room, facing R64 but assisting his roommate. R64 was observed to bend over and attempt to pick something up off the floor. R64 was observed to walk out of his room with no walker and barefoot while occasionally using the wall for assistance when he stumbled, and NA-B was not observed reminding him to use his walker. R64 was observed to turn around and walk back into the room. R64 was observed to sit down in a chair and put socks on. R64's walker was not within reach from this R64's chair but was on the far side of the room. NA-B was then observed to leave the room and was not observed to move the walker closer to R64 or remind him to use it if he got up. At 9:24 a.m., R64 was observed stumbling towards the walker that was on the far side of the room and caught himself on the double closet doors. R64 was then observed to walk back to his chair without his walker and sit back down. On observation, signs, or visual reminders for R64 to use his walker were not noted. During an interview and observation on 8/6/24 at 9:32 a.m., NA-B stated she worked with R64 multiple days a week. NA-B stated R64 was independent with ambulation but was supposed to use his walker but commonly forgot it. NA-B acknowledged she had noticed R64 walking without his walker but had not attempted to redirect or remind R64 to use his walker before leaving the room. NA-B stated she thought he might have fallen in the past previously but was unsure. NA-B was observed reviewing R64's Kardex and stated it indicated R64 was supposed to have assistance while walking but no one [facility staff] provided assistance to R64 during ambulation. (continued on next page)

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	08/07/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/24 at 12:36 p.m., the assistant director of nursing (ADON) stated R64 had fallen on 7/19/24 and after reviewing the medical record and the incident report with related notes dated 7/19/24, a fall analysis that had related interventions had not yet been implemented. The ADON stated R64 was impulsive, and they had talked about possible fall interventions this week, and they were going to implement a reminder such as signs in R64's room to remember his walker but had not gotten to it yet. The ADON stated R64 was independent with ambulation but needed frequent reminders to use his walker. The ADON stated R64's care plan and Kardex had not been updated to demonstrate this and continued to show he needed assistance with ambulation. The ADON stated she would now update the care plan and Kardex to demonstrate R64's current independence with ambulation with reminders to use a walker. During an interview on 8/7/24 at 1:28 p.m., the director of nursing (DON) stated they reviewed falls every morning and discussed possible root causes and ideally, this would be documented with appropriate care plan interventions but that might not always have been occurring. The facility Falls and Fall Risk Managing policy dated 10/4/21 indicated facility staff would identify fall interventions based on the resident's specific risk factors and potential fall causes to prevent further falls.

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	08/07/2024

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview, and document review the facility failed to comprehensively assess past trauma and develop a comprehensive person-centered care plan with goals and interventions utilizing a trauma-informed approach including monitoring of PTSD (post-traumatic stress disorder) for 1 of 1 (R76) residents reviewed for trauma-informed care. Findings include: R76's admission Minimum Data Set (MDS), dated [DATE], identified R76 with moderately impaired cognition and diagnoses included: PTSD, bipolar disease (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder, and fibromyalgia (medical syndrome which caused chronic widespread pain). R76's Trauma Informed Care History Assessment, dated 6/27/24, identified R76 as alert, orientated and cognitively intact. The document identified through a question with a radio-button answered yes that R76 experienced any life traumatic events. The assessment form disclosed a traumatic event that happened to R76 related to her time in military service. Furthermore, assessment indicated are you aware of any particular triggers that may make this worse for you, the box below had a typed response of N/A. R76's care plan, printed 8/6/24, indicated a PASARR [preadmission screening and resident review] screening has determined that a serious mental disorder, intellectual disability or related disorder exists (Bipolar, PTSD) with an intervention of coordinate PASARR Level II recommendations. Psychiatry referral as ordered. The care plan lacked evidence of any other mention of R76 suffering from PTSD, discussing possible triggers, interventions to determine triggers, measurable objectives, interventions, and timeframes for how staff are expected to meet R76's desired goals and outcomes concerning her PTSD. Furthermore, the document identified R76 was dependent on staff etc. for meeting emotional, intellectual, physical, and social needs r/t [related to] cognitive deficits, physical limitation. During an interview on 8/07/24 at 10:05 a.m., R76 was observed lying in bed. R76 stated, No one from here has ever talked to me about any of my past trauma .I have sexual trauma from the military .I would like it if someone would talk to me .I do have triggers that make it worse .Sometimes when the men lean over me to provide cares, it triggers me, I know they have to do that when they provide cares but it does trigger me at times. R76 stated she would like to work with the social worker to identify triggers as no one has ever asked me about what triggers me. On 8/07/24 at 11:09 a.m., nursing assistant (NA)-D verified they are familiar with R76. NA-D stated they are not sure if R76 has PTSD or any triggers. On 8/06/24 at 3:36 p.m., NA-C verified they are familiar with R76 and work with her often. NA-C stated they are not aware if R76 has PTSD or any triggers that make it worse. NA-C stated they received training on trauma informed care. (continued on next page)

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	08/07/2024

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/07/24 at 11:18 a.m., registered nurse (RN)-C verified they are responsible for R76's care and familiar with her care. RN-C stated they are unsure if R76 has PTSD or any known triggers. After review of care plan, RN-C verified there was no documentation on the care plan relating PTSD except for reference to diagnosis with the PASARR. RN-C verified there were no interventions to determine any triggers, known triggers, or for staff to assess for triggers in R76's care plan. On 8/07/24 at 1:21 p.m., social worker (SW) verified that she is familiar with R76. SW stated that she has visited with R76 about her time in the military. SW verified she has not talked with R76 about any triggers. SW verified R76 did not identify any triggers for R76. SW stated a trauma informed assessment was completed upon assessment and verified that N/A stands for not applicable. On 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated that she believes staff get trained on trauma informed care annually and during orientation. ADON stated, I do not know if it [PTSD] is on the care plan when asked about R76 diagnosis and triggers. A facility policy titled Trauma-Informed and Culturally Competent Care, dated 10/18/22, was provided. The document purpose is to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. In the section Resident Care Planning it identified to develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate.

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	08/07/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on interview and document review, the facility failed to act upon the consultant pharmacist's recommendation for 1 of 1 resident (R13) reviewed for unnecessary medications. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 was cognitively intact, did not experience hallucinations or delusions and did not refuse cares. MDS indicated R13 needed extensive assistance with transfers, hygiene, bathing, and dressing. R13 needed set up with oral hygiene and eating. R13's Clinical Diagnosis report printed 8/7/24, indicated Parkinson's disease with dyskinesia (disorder of the central nervous system that affects movement, often including tremors), dementia with other behavioral disturbances, neurocognitive disorder with Lewy Bodies (type of dementia characterized by build up of protein deposits in regions of the brain memory, thinking and movement) , essential hypertension(abnormally high blood pressure that's not the result of a medical condition) , and vitamin d deficiency. R13's Clinical orders report printed 8/7/24, included an order dated 9/11/23 for quetiapine (an antipsychotic medication) 25 milligrams (mg) at bedtime for hallucinations. R13's Consultant Pharmacist Recommendation to Physician dated 4/16/24 and 7/20/24 indicated the quetiapine 25 mg dose was active since 3/7/22. Recommendation read Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR [gradual dose reduction] in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, A GDR must be attempted annually, unless clinically contraindicated. The recommendation included a message directed to the provider, as follow: Resident is due for a dose reduction assessment. During your next visit could you please review whether resident continues on the lowest doses of his/her regimen. If a dose is contraindicated, please document clinical rationale below. Both recommendations did not contain documentation showing and answer to the recommendations. During interview on 8/6/24 at 3:26 p.m., assistant director of nursing (ADON) stated the facility switched providers in April. In July, in order to make changes to the residents' psychotropic medications the new nurse practitioner requested a detailed psychosocial review and when the last GDRs were done for each resident. ADON stated the psychosocial reviews were on her to do list. During interview on 8/7/24 at 2:02 p.m., director of nursing (DON) stated the previous nurse practitioner left on April 10th. DON stated when the new nurse practitioner started, she didn't want to make any changes without knowing the residents. DON stated in July she asked for the psychosocial reviews and our ADON will be working on them. DON verified the pharmacist recommendations for the month of April and July were not done. (continued on next page)

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	08/07/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility title Medication Monitoring and Management, Antipsychotics dated 5/2022, indicated If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

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	08/07/2024

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to administration of as-needed (PRN) narcotic medication to reduce the risk of potential complications for 1 of 5 residents (R4) reviewed for unnecessary medication use. Findings include: R4's admission Minimum Data Set (MDS), dated [DATE], identified R4 had intact cognition and consumed opioid (i.e., narcotic) medication during the review period. R4's care plan, dated 8/5/24, identified R4 had potential for pain due to recent hip surgery. A goal was listed which read, . will not have an interruption in normal activities due to pain through the review date, along with several interventions to help R4 meet this goal including, The resident's pain is alleviated/relieved by: Ice, rest, pain medications. The intervention start date was recorded as, 08/05/2024. R4's Order Summary Report, signed 7/29/24, identified R4's physician orders while at the care center. This included an order which read, HYDROmorphone HCL [Dilaudid, a narcotic] Oral Tablet 2 MG [milligrams] . by mouth every 6 hours as needed . , with a start date recorded, 07/22/2024. R4's corresponding SKILLED note, dated 7/29/24, identified R4 was seen by the nurse practitioner (NP) for a follow-up visit with notation of R4 having been hospitalized until 7/9/24 for a femur fracture and post-surgical infection. The note outlined R4's pain regimen with dictation, . Reports pain increased overnight last night and some difficulty sleeping but overall well controlled. Seen working with PT [therapy] prior to visit and no observed significant pain. PT reports [R4] is able to perform all exercises with some pain but overall she does not feel it is interfering with [R4] progress. The NP identified R4 was consuming the narcotic 2-3 times per day and listed several orders including, DECREASE dilaudid frequency to BID PRN [twice daily, as needed] - separate doses by at least 4 hours. On 8/7/24 at 8:52 a.m., R4 was observed in the dining room on her unit. R4 finished eating and stood up next to the table with nursing assistant (NA)-I immediately beside her. R4 took several steps using a front-wheeled walker and ambulated down the hallway to her room without any obvious physical signs of pain (i.e., grimace, moaning) present. Following, at 9:01 a.m., R4 was interviewed and stated she felt her pain was being well-managed at the care center. R4 stated she was taking the hydromorphone since I've been here and expressed the NP was trying to take me off it before I go home. R4 stated the staff had not offered or asked about ice packs or heat packs before giving the narcotic before but expressed she was open to trying such interventions, if offered. R4's Medication Administration Record (MAR), dated August 2024, identified R4's consumed medications for the month-period. This included R4's hydromorphone with directions, . 2 mg by mouth every 12 hours as needed ., with a corresponding pain level being written with each recorded administration. A total of six administrations for the month, so far, had been recorded as follows: (continued on next page)

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	08/07/2024

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 3:30 a.m., for pain rated nine out of 10 with the dose being effective. A corresponding progress note, dated 8/1/24, identified the medication was given with dictation, . Resident requested and given for right hip pain. Rated pain as 9/10 on the pain scale. However, the note lacked further information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/2/24 at 12:17 a.m., for pain rated 10 out of 10 with the dose being effective. A corresponding progress note, dated 8/2/24, identified the medication was given with dictation, . Resident requested and given for right hip pain. Rated pain as 10/10 on the pain scale at this time. However, the note lacked further information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/2/24 at 11:17 p.m., for pain rated nine out of 10 with the dose being effective. A corresponding progress note, dated 8/2/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/4/24 at 1:28 a.m., for pain rated nine our of 10 with the dose being effective. A corresponding progress note, dated 8/4/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/4/24 at 7:05 p.m., for pain rated 10 out of 10 with the dose being effective. A corresponding progress note, dated 8/4/24, identified the medication was given with dictation, . Res c/o [complain] pain 10/10 on right hip. However, the note lacked further information on what, if any, physical symptoms were demonstrated (i.e. , grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/5/24 at 7:41 a.m., for pain rated eight out of 10 with the dose being effective. A corresponding progress note, dated 8/5/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. R4's medical record was reviewed and lacked evidence non-pharmacological interventions had been attempted prior to the administration of the PRN narcotic medication despite newly care-planned, effective non-pharmacological interventions for her pain being listed and the medical provider actively trying to decrease the frequency of the narcotic use. When interviewed on 8/7/24 at 9:48 a.m., NA-F stated they had worked with R4 prior but had not, at least to their recall, ever heard R4 complain about pain adding, I've never heard her. NA-F stated they had not offered or given R4 ice packs or anything; nor had they ever been told to by the nurses adding, Not that I know of. NA-F verified R4 was working with therapy and reiterated R4 had not complained about pain to their recall adding, I never see her do that [pain symptoms]. (continued on next page)

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	08/07/2024

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 9:51 a.m., registered nurse (RN)-A was interviewed. RN-A verified they had worked with R4 prior and explained she (R4) had hydromorphone ordered two times max a day for pain. RN-A stated R4 would most often have pain in the early morning but added the pain, overall, seemed to be going down a little bit. RN-A stated with use of as-needed pain medications, including narcotics, the staff should be trying ice or topicals prior to giving it. RN-A reviewed R4's medical record and stated R4 used to have an order for ice to be applied but added, We might have taken it out. RN-A verified non-pharmacological interventions should be attempted prior to a as-needed narcotic being given and recorded in the progress notes adding, Technically, that's what were supposed to do. RN-A stated it was important to attempt non-pharmacological interventions and chart them to help ensure the least dose of medication is used adding, If it's not charted, it's not done. When interviewed on 8/7/24 at 11:25 a.m., registered nurse manager (RN)-E verified they had reviewed R4's medical record, and they could not find anything non-pharmacological [recorded], adding further, The expectation is they're offered prior. RN-E stated the care center was looking into building non-pharmacological use into the order set and verified they should be offered, attempted and recorded with as-needed narcotic use adding such was important due to medications can have side effects, so if they can be avoided [better]. A facility' policy on as-needed narcotic management was not provided.

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	08/07/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure an appropriate indication was given for continued antipsychotic medication use for 1 of 5 residents (R68) reviewed for unnecessary medications. Findings include: R68's quarterly Minimum Data Set (MDS) dated [DATE], indicated R68 had severely impaired cognition and was diagnosed with dementia, anxiety, depression, and a stroke. The MDS indicated R68 had no signs of psychosis such as hallucinations or delusions and did not have behavioral symptoms during the look-back period (LBP). The MDS indicated R68 was dependent on staff for all activities of daily living and was receiving hospice services. R68's medical diagnoses report dated 1/16/24, indicated R68 had dementia without behavioral disturbance. R68's Order Summary Report dated 1/16/24, included an order dated 1/16/24, for quetiapine (an antipsychotic medication) 12.5 milligrams (mg) every evening for agitation. R68's care plan dated 1/29/24, indicated R68 had a behavioral problem related to dementia and would call out for family members as well as experience hallucinations and delusions. The care plan indicated facility staff were to document behaviors and the potential causes. The care plan indicated staff could intervene by giving reassurance, using distraction, rest, or providing a less stimulating environment. The care plan dated 1/17/24, indicated R68 used psychotropic medications related to dementia and end of life. The care plan indicated staff were to record occurrences of target behavior symptoms including agitation, restlessness, sadness, and isolation. R68 Medication Administration Record (MAR) dated 5/1/24 through 8/6/24, indicated nursing staff were to document if behaviors were observed related to quetiapine use and no was charted daily during the period. R68's Behavior Monitoring and Interventions report dated 5/21/24 through 8/8/24 indicated, facility staff documented whether R68 had behaviors, what these behaviors were, and what interventions were taken approximately every shift. All entries during this period were documented as no behaviors observed or not applicable. R68's progress note dated 5/21/24 at 12:42 p.m., indicated R68 was sleeping and had no behaviors or hallucinations that morning. R68's provider note dated 5/21/24, indicated R68 was declining and was on hospice. The note indicated R68 was mostly sleeping and mostly nonverbal. The note indicated R68 was confused but had no behaviors. (continued on next page)

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	08/07/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R68's Consultant Pharmacist Recommendation to Physician dated 6/23/24, indicated R164 was receiving quetiapine for a diagnosis of agitation which is not considered an appropriate indication for antipsychotic use. The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 7/15/24 by indicating the associated diagnosis was behavioral or psychological symptoms of dementia (BPSD) that present a danger to the resident or others. R68's provider note dated 7/22/24, indicated R68 had severe dementia and was nonverbal. The note indicated R68 appeared comfortable and was sleeping. The note did not indicate what behaviors or psychological symptoms of dementia that R68 had that would present a danger to R68 or others. R68's progress note dated 8/3/24 at 8:33 a.m., indicated R68 had yelled out for family early in the morning but was now sleeping. R68's progress notes dated 5/21/24 through 8/5/24 were reviewed and did not indicate R68 had presented with behaviors that were a danger to the resident or others. During an interview and observation on 8/6/24 at 9:22 a.m., nursing assistant (NA)-A stated she worked with R68 frequently and had noticed that he got confused. NA-A stated if R68 was left in his wheelchair for a while, R68 would become very uncomfortable and then somewhat restless but once they would move him out of his wheelchair into bed, they did not notice any restlessness. NA-A stated she had not noticed R68 having any other behaviors. R68 was observed sitting in his wheelchair in his room with his eyes closed and no signs of agitation. During an interview on 8/6/24 at 1:59 p.m., NA-B stated R68 was always sleeping and she had not noticed any behaviors or agitation. During an interview on 8/6/24 at 2:00 p.m., registered nurse (RN)-F stated she was the nurse in charge of R68's care. RN-F stated R68 was usually just dosing off and she had not noticed any behaviors or signs of agitation. During an interview on 8/7/24 at 11:17 a.m., nurse practitioner (NP)-A stated she had been working with R68 since April of this year. NP-A stated it looked like quetiapine had been started in January for behavioral issues. NP-A stated she had signed the pharmacist review dated 6/23/24. NP-A stated the resident was so new to her so she was unsure if R68 was currently or previously had behavioral symptoms that were a danger to himself or others. NP-A stated she now reviewed the medical record and did not see any behaviors documented since April of this year. NP-A stated she was not sure why behavioral or psychological symptoms of dementia (BPSD) that present a danger to the resident or others was the diagnosis chosen as she did not see documentation that this was correct. NP-A stated if R68 was having behavioral symptoms warranting antipsychotic use, she would have expected nursing staff to document these symptoms. NP-A stated she would defer to the assistant director of nursing (ADON) as she knew the resident and what behaviors he might be presenting with, better than she would. During an interview on 8/7/24 at 12: 42 p.m., the ADON stated she had reviewed the medical record and did not see any evidence of active behaviors or signs of agitation for R68. The ADON stated she knew he had a history of hallucinations but did not see evidence in the medical record that those were still present. The ADON stated she had reviewed R68's pharmacist review dated 6/23/24 and acknowledged that R68 did not have any behaviors that made him a danger to himself or others and was unsure why the provider had selected that as the diagnosis. (continued on next page)

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	08/07/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy dated Medication Monitoring and Management dated 5/22, was received but did not address indications for antipsychotic use.

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	08/07/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure the need for routine dental care (i.e., dental appointment) was assessed and, if needed or wanted, offered to promote oral hygiene and reduce the risk of complication for 1 of 1 resident (R4) reviewed who reported losing their dentures just prior to admission. Findings include: R4's admission Minimum Data Set (MDS), dated [DATE], identified R4 admitted to the care center on 7/9/24 from the acute care hospital. The MDS outlined R4 had intact cognition and demonstrated no delusional thinking. Further, The MDS recorded under, Section L - Oral/Dental Status, R4 had no broken or loosely fitting dentures, abnormal mouth tissue, or obvious cavities with a check placed next to the option reading, Z. None of the above were present. R4's Clinical Census listing, printed 8/6/24, identified R4's current payer source was listed as, MSHO Medicaid. On 8/5/24 at 1:15 p.m., R4 was interviewed and stated she admitted to the care center about a month prior. R4 was asked if she had any issues with her teeth or dental care while at the care center, and R4 responded she had no teeth on the top palate and only a few remaining on the bottom palate. R4 stated she had lost my dentures at the hospital prior to admitting to the care center and, so far, nobody from the care center had discussed or asked about getting a dental appointment made to possibly get new ones. R4 reiterated she'd like to pursue getting new dentures, if able, adding not having them was frustrating as it was hard to chew without [them]. R4's Nurse Admission/Readmission 05212021 - V15, dated 7/10/24, identified R4 admitted from the hospital and listed a primary rationale for admission, TCU- [transitional care unit]. The evaluation contained a section labeled, Oral Status, which had a checkmark placed next to the option reading, Broken or loose fitting full or partial denture ., and a location of broken, carious or missing teeth listed, Upper gum. The evaluation outlined R4 used an upper denture and a partial lower denture; however, the evaluation lacked any information or evidence of when R4's last dental visit had been or if was was currently wanted/needed. R4's Social Service Care Conference - IDT 03302021 - V3, dated 7/26/24, identified R4's care conference was held with R4 present. The form outlined spaces for respective disciplines to record information including, Section E: Social Services, which contained a subsection asking, Any referrals needed (podiatry, optometry .):, however, this section was left blank. The completed summary lacked evidence what, if any, appointments were asked or offered to R4. R4's care plan, dated 8/5/24, identified a section for oral health which was initiated on 8/5/24 and outlined, The resident has potential oral/dental health problems r/t [related to] denture fit. The care plan listed interventions to help R4 remain free of oral infection or pain which included, Coordinate arrangements for dental care, transportation as needed/as ordered. (continued on next page)

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	08/07/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 8/6/24 at 10:08 a.m., nursing assistant (NA)-F stated they had worked with R4 prior. NA-F explained R4 did not, at least to their knowledge, have their own teeth and used dentures but often didn't wear them adding, I've never seen her put it on [in] before. NA-F stated they were unsure if R4's dentures were even at the care center or not and expressed R4 had never made any comments about them. NA-F stated any dental appointments, if needed or wanted, would be made by the nurses. At 10:11 a.m., NA-F and the surveyor checked R4's room for what, if any, dentures were present. R4 was present laying in her bed and stated aloud, I don't have none. NA-F verified no dentures were present. R4's medical record was reviewed and lacked evidence R4 had been asked, offered or referred to a dental provider despite admitting to the care center nearly a month prior and being assessed upon admission as having potential broken or loose-fitting dentures. When interviewed on 8/6/24 at 10:23 a.m., licensed practical nurse (LPN)-B stated dental care, including the need or desire for an appointment, was done upon admission and recorded in the admission assessment [i.e. , Nurse Admission/Readmission]. LPN-B stated if there was concerns or complaints about dentition then, it would be referred to the dental provider and, if not, then re-evaluated in three months during the next routine review (i.e., MDS cycle). At 10:25 a.m., the medical records coordinator (MRC) joined the interview and verified they scheduled appointments for the campus. MRC stated R4 had not yet been scheduled for any dental appointments and nobody had referred any concerns about it to them. MRC stated they would go follow-up with R4 about it. On 8/6/24 at 1:44 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had followed up on R4's dental appointment adding MRC was working on getting R4 scheduled for one now. ADON stated the nurses complete the admission assessments and, from that, information gets pulled to the care plan adding the care conference is also an opportunity to record what, if any, appointments are needed or offered but R4's section was blank. ADON stated residents' on the TCU are usually more therapy focused but verified dental appointments and the need for such should be looked at. ADON verified the medical record lacked evidence R4 had been offered or evaluated for what, if any, dental appointments were needed or wanted; and expressed the care center was looking at their assessments to see if they could add more to them to ensure it was addressed. ADON stated it was important to ensure dental needs were offered or provided to ensure we're getting their needs [met] and continuity of care. A provided Dental Services policy, dated 2/2022, identified routine and emergency dental services were available to meet resident' oral health needs in accordance with the assessment and plan of care. The policy outlined the social services team would assist with appointments, transportation arrangements and reimbursement, if needed. The policy concluded, All dental services provided are recorded in the resident's medical record.

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	08/07/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview and document review, the facility failed to take appropriate steps to ensure the proper sanitization of dishware used for meal preparation and resident service when 1 of 1 high-temperature commercial dishwashers was identified as not reaching adequate final rinse temperature (i. e., 180 F). This had potential to affect all 80 residents within the nursing home, staff, and visitors who consumed food from the main production kitchen. Findings include: On 8/5/24 at 7:06 p.m., a kitchen tour was completed with dietary staff (DS)-A and DS-B present. A single [NAME] Tempstar commercial dishwasher was present along the wall with several hard plastic racks placed in front of the machine on the floor. DS-B loaded several metallic cookware pans onto other hard plastic racks and placed them into the dishwasher. A single, white-colored gauge present on top of the machine which did not move for the entirety of the wash or rinse cycle. A silver-colored plate was mounted to the side of the machine, under the counter area, which identified the make and model of the dishwasher along with, Minimum Rinse Temperature . 180 F [Fahrenheit]. DS-B moved the stacked hard-plastic racks from in front of the machine which exposed two, white-colored analog gauges labeled, R and W, respectively. Both gauges were covered with a hard white film. DS-B stated these gauges were for the dishwasher temperatures. DS-B stated she is not able to read the gauges and requested DS-A assistance. DS-A verified that she cannot read the gauges on the dishwasher. DS-A verified that she does write on the dishwasher temperature log and verified again that she is unable to read the gauges due to the gauges being full of a hard white film. Surveyor was unable to read the temperature on the gauges. On 8/06/24 at 8:13 a.m., an additional follow-up kitchen tour was completed with dietary manager (DM). DM verified the dishwasher is a high temperature dishwasher and needs to 180 F. DM rinsed a few dishes, set them in onto other hard plastic racks and placed them into the dishwasher. The dishwasher was run at least four times with the highest temperature of 172 F. DM stated the dishwasher was serviced last week. DM stated it is important the dishwasher is reaching 180 F so the dishes are getting sanitized or there is risk for food borne illnesses. On 8/6/24 at 8:37 a.m., DS-A verified that when they checked the temperature on the dishwasher this morning it was 121 and 127 degrees, and verified the log sheet was not recorded correctly. DS-A verified, the dishwasher did not reach 184 this morning even though the log sheet says it does. On 8/06/24 at 2:22 p.m., administrator verified that he was notified this morning of the dishwasher not reaching temperature and was going to follow up now to see if the service company had been out today to fix the issue. Administrator stated that if the issue has not been addressed then the facility would be using paper and plastic products until the dishwasher is fixed to ensure resident safety. (continued on next page)

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	08/07/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/06/24 at 2:35 p.m. DM and administrator met with surveyor. DM informed surveyor that the dishwasher was reaching temperature and dishwasher cycle and was observed to have reached 184 F. DM stated, we ran a lot of cycles to get it to hit temp, and verified the cycles ran this morning with temperatures not meeting the required 180 F. Administrator stated the facility will use paper and plastic until the dishwasher can be serviced due to the inconsistency of the temperatures. On 8/07/24 at 11:45 a.m., administrator updated surveyor that the dishwasher was just fixed. Administrator stated they fixed a pressure valve that was malfunctioning causing the dishwasher to not reach temperature consistently. During observation on 8/07/24 at 12:06 p.m., temperature on dishwasher was observed and reached 186 F. A provided Cleaning Dishes/Dish Machine policy, dated 2017, identified all flatware, serving dishes, and cookware will be cleaned, rinsed and sanitized after each use. The policy outlined, Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitiation [sic], along with a corresponding table which outlined the type(s) of dish machines and their corresponding final rinse temperatures. This included, High Temperature Dishwasher . 180 F.

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	08/07/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and document review, the facility failed to ensure recommended pneumococcal immunizations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 1 of 5 residents (R18) reviewed for immunizations. This had the ability to affect all 80 residents residing the in the facility Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified several tables with corresponding recommendations when to receive various versions (i.e., PPSV23, PCV13, PCV20) of the pneumococcal vaccine. The graph labeled, Adults 19-[AGE] years old with chronic health conditions ., identified persons who received only a PPSV23 had an option to either get a PCV15 or PCV20 a year after the last PPSV23 dose. The conditions listed including alcoholism and cigarette smoking. Further, The graph labeled, Adults [at or older than] [AGE] years old, outlined persons with a complete series of pneumococcal vaccination (i.e., PCV13 at any age, PPSV23 at or above [AGE] years old) should have shared clinical decision-making between the resident and healthcare provider to determine if PCV20 was appropriate. R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 admitted to the facility in March of 2024, was [AGE] years old and had intact cognition. R18 had diagnoses of Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), anemia, high blood pressure, kidney failure, anxiety, and depression. R18's Minnesota Immunization Information Connection form dated 3/22/24 indicated R18 received the PPPSV23 most recently on 10/4/07, and received the PCV-13 on 1/26/15, prior to her admission. R18's PointClickCare (electonic medical record) Clinical Immunization form, printed 8/7/24, did not include further record of a pneumococcal vaccine. A review of R18's medical record did not include, based on shared clinical decision making, R18 had been offered and/or provided the PCV-20 per CDC guidelines. A facility form titled Revolving Immunization Consent or Declination, dated, 3/12/24 and signed by R18 indicated R18 consented to receive the influenza vaccination, the pneumococcal vaccination, and the COVID vaccination per CDC guidelines. (continued on next page)

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	08/07/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/6/24 at 2:25 p.m., the assistant director of nursing (ADON) verified responsiblity as the facility's infection preventionist (IP). The ADON explained when a resident admitted to the facility, the admission nurse was responsible for consenting the resident for vaccines and providing the Vaccine information Sheet (VIS). The ADON stated the consent forms were reviewed and entered into the vaccine spreadsheet tracking log to maintain which residents consented to receive or declined the vaccines. The ADON stated a resident's immunization records were reviewed and the CDC's mobile app, PneumoRecs VaxAdvisor, was utilized to determine a resident's pneumococcal vaccination eligibility. The ADON stated it was important to assess a resident's vaccination status and offer eligible vaccinations because residents living in closer quarters, and it placed them at a higher risk for getting things. The ADON reviewed the spreadsheet tracking log for R18 and stated it appeared R18 had refused the pneumococcal vaccinations. The ADON reviewed R18's electronic health record (EHR) and verified her consent to receive the pneumococcal vaccination dated 3/12/24 and verbalized being unsure of what happened, but maybe it fell through the cracks. The ADON stated R18 initially refused the vaccinations but later changed her mind and the spreadsheet was not updated. During interview on 8/7/24 at p.m., the director of nursing (DON), stated there was a formal audit system in place to ensure vaccinations statuses are checked and updated and stated the vaccination would of been found on the next audit. A facility policy titled Pneumococcal Vaccine last reviewed 7/24, indicated all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy indicated prior to admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Furthermore, the policy indicated assessments of pneumococcal vaccination status would be conducted within five (5) working days of the resident's admission if not conducted prior to admission, and administration of the pneumococcal vaccines or revaccinations would be made in accordance with current CDC recommendations at the time of the vaccination.