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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0D9Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00997

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245063**
2.STATE VENDOR OR MEDICAID NO.
(L2) **491343400**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ANTHONY PARK HOME**
(L4) **2237 COMMONWEALTH AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55108**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/15/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **84** (L18)

13.Total Certified Beds **84** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 12/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/04/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/01/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5063

Electronically Delivered: December 17, 2014

Mr. John Barker, Administrator
St Anthony Park Home
2237 Commonwealth Avenue
Saint Paul, Minnesota 55108

Dear Mr. Barker:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 5, 2014 the above facility is certified for:

84 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 84 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: December 17, 2014

Mr. John Barker, Administrator
St Anthony Park Home
2237 Commonwealth Avenue
Saint Paul, Minnesota 55108

RE: Project Number S5063025

Dear Mr. Barker:

On November 13, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 30, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 8, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 30, 2014, effective December 5, 2014 and therefore remedies outlined in our letter to you dated November 13, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245063	A. Building B. Wing	12/15/2014

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **10/31/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **12/05/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/05/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/05/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **10/31/2014**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **12/05/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/05/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/05/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	12/17/2014	16022	12/15/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/30/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245063	A. Building B. Wing **01 - MAIN BUILDING 01**	12/8/2014

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **11/17/2014**	ID Prefix	Correction Completed **11/17/2014**	ID Prefix	Correction Completed **12/04/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0050		LSC K0052		LSC K0067	
ID Prefix	Correction Completed **12/04/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	12/17/2014	12424	12/08/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/28/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0D9Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00997

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245063**
2.STATE VENDOR OR MEDICAID NO.
(L2) **491343400**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ANTHONY PARK HOME**
(L4) **2237 COMMONWEALTH AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55108**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/30/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **84** (L18)

13.Total Certified Beds **84** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 11/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/04/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 13, 2014

Mr. John Barker, Administrator
St Anthony Park Home
2237 Commonwealth Avenue
Saint Paul, Minnesota 55108

RE: Project Number S5063025

Dear Mr. Barker:

On October 30, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 9, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 9, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by January 30, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 30, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a written policy to report alleged incidents of abuse and neglect to the administrator immediately. This had the potential to affect all 75 residents residing in the facility. Findings include: Review of the facility undated abuse policy,labeled St. Anthony Park Home Vulnerable Adult Act Policy, indicated the following: "Reporting / Response:	F 226	Policy to notify administrator has been changed from "as soon as possible" to "immediately"	10/31/14

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

Electronically Signed | 11/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY PARK HOME	**2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108**

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F 226	Continued From page 1 The administrator must be contacted as soon as possible, but not more than 24 hours, of any alleged incident (the 24 hours begins when an employee of the facility has received the complaint)." Interview with the administrator at 9 a.m. on 10/29/14, verified the policy directed staff to report incidents as soon as possible and not immediately. The Administrator stated that staff do immediately report to the administrator, but it was not in the policy. Interview with activity aide (AA)-A, on 10/28/14 at 3:40 p.m., identified the administrator and nurse would be notified immediately. Interview with licensed practical nurse (LPN)-B on 10/29/14 at 10:08 a.m., LPN-B stated would tell the Director of Nursing and the Administrator immediately upon discovering or being notified of alleged abuse or neglect. Interview with the social service director on 10/29/14 at 2:41p.m., indicated the administrator is notified immediately upon hearing about any reports of neglect or alleged abuse. Interview with the activity director on 10/30/14 at 11:13 p.m., explained the process is to notify the administrator immediately of any possible abuse. Review of the facility's reported Vulnerable Adult (VA) reports on 10/29/14 revealed the following: VA report for R104, on 8/29/14, was reported to the administrator immediately. VA report for R40, on 8/18/14 of possible neglect, was reported to the administrator immediately. VA report for R43, on 10/29/14, was reported to	F 226		

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F 226	Continued From page 2 the administrator immediately.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide food choices for 2 of 35 residents (R44, R104) reviewed for choices. Findings include: During the evening meal observations on 10/27/14, at 6:00 p.m., R44 expressed being frustrated and stated, "The kitchen staff do not listen to my request for no cold meat sandwiches, look at this, they gave me a cold meat sandwich when everyone else got egg salad." R44 explained that this concern had been discussed with kitchen staff on numerous occasions. R44 said that staff have had to switch out the cold meat sandwiches on numerous occasions because R44 continues to recieve the cold meat sandwiches. During this same meal at 6:00 p.m., R104 expressed frustration because R104 has told the	F 242	St. Anthony Park Home will provide residents 44 and 104 the choice of food they request. An in-service will be conducted with dietary personnel, regarding the resident□s likes, and dislikes, which are recorded on their diet card. A cook or the dietary manager will ask resident 44 and 104, on a daily basis, whether or not the diet card has been followed. The registered dietician will follow up with resident 44 and 104 two times a month to ensure compliance with this citation. Please note: the administrator was miss quoted in the findings. The administrator was never asked if the facility had a food committee. The facility does document any and all complaints about the food that are reported at resident council meetings. If during a meal a resident asks for a grilled cheese sandwich instead of what they were served that request would not be documented as a grievance. St. Anthony	12/5/14

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F 242	Continued From page 3 kitchen and nursing staff on numerous occasions of wanting only tomato soup. R104 explained that he/she fills out a menu to reflect tomato soup and does not receive the tomato soup. On 10/27/14, the menu identified tomato soup as an alternate and R104 received cheddar cheese soup. Interview with the food service manager (FSM) on 10/29/14 stated there was not a separate food committee at the facility but the FSM explained that she meets with residents on Fridays and during care conferences. When questioned regarding R44 and R104 concerns, the FSM indicated that if residents have food concerns, the concerns would be documented in the nutritional services care conference section, in the resident's record. A review of the nutritional services care conference section was conducted for R44 and R104's food concerns and lacked documentation of any food choices or concerns. Review of monthly family council minutes showed no documentation of food quality or concerns. Interview with the administrator on 10/29/14, at 10:30 a.m., administrator explained that he conducts the resident council meetings but does not document food item concerns. When asked if there was a separate committee or meeting to discuss food quality and concerns, the administrater stated there was not a separate food committee and said if there was a problem the facility takes care of it right away.	F 242	Park Home does not believe that is a grievance in the spirit of F166 and that is the context of the conversation that the surveyor and the administrator had.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		12/5/14

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F 282	Continued From page 4 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 3 residents (R32) reviewed for rehabilitation. Findings include: R 32's care plan (CP) dated 9/30/14, indicated R32 had limited physical mobility, with the goal of increasing mobility by ambulating with nursing to and from the dining room and bathroom. The CP directed the staff to ambulate R32 with SBA (stand by assist) of 1 staff using a 2 wheel walker. R32 was observed 10/29/14 at 8:15 a.m. being transferred from the bed to the wheel chair with the assist of 2 nursing assistants (NA)-A and NA-B. R32 took a few steps with assist from NA-A and NA- B. When asked whether R32 was able to ambulate, NA-A and NA-B both indicated, R32 only walked with physical therapy. When interviewed on 10/29/14 at 9:45 a.m., Licensed practical nurse (LPN)-A indicated when a resident was to be ambulated by nursing after completion of PT, there should be an ambulation record. LPN-A indicated there was no documentation to indicate nursing was ambulating R32 and confirmed that the care plan directed nursing to ambulate R32.	F 282	St. Anthony Park Home will ambulate resident 32 as directed by the ambulation flow sheet, unless the resident refuses. Nursing will document each day whether the resident walked or refused. This will apply to all residents who have an ambulation flow sheet. The flow sheets will be monitored on a daily basis by nursing administration, licensed nursing, and therapy. Nursing assistants will be in serviced on the requirements of the maintenance ambulation program. The administrator will review the ambulation records on a weekly basis to ensure compliance.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		12/5/14

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F 311	Continued From page 5 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services for 1 of 3 residents (R32) to help maintain or improve ability to ambulate. Findings include: R32 was observed 10/29/14 at 8:15 a.m. being transferred from the bed to the wheel chair with the assist of 2 nursing assistants (NA)-A and NA-B. R32 took a few steps with assist. During interview, at this time, with NA-A and B, the nursing assistants were asked whether R32 was able to ambulate both stated that R32 only walked with physical therapy. Review of the medical record identified R32 was admitted from the hospital 9/19/14, following a fall at home with no injuries. Upon admission R32 received physical therapy (PT) five days a week. PT was discontinued on 10/2/14 due to goals being met to residents highest level of functioning and the therapist sent a communiqué to all nursing staff and nurse aides on 9/22/14 which read, "please ambulate [R32] 1/2 way to all meals using his 2 wheeled walker with stand by assist (SBA)." The admission minimum data set (MDS) dated 9/25/14, for ambulation, identified R32 required extensive assistant of one person. The 30 day MDS dated 10/18/14 stated the same.	F 311	St. Anthony Park Home will ambulate resident 32 as directed by the care plan, unless the resident refuses. Nursing will document each day whether the resident walked or refused. This will apply to all residents who have ambulation on their care plan. The flow sheets will be monitored on a daily basis by nursing administration, licensed nursing, and therapy. nursing assistants will be in serviced on the requirements of the maintenance ambulation program. The administrator will review the ambulation records on a weekly basis to ensure compliance.	

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F 311	Continued From page 6 The care plan (CP) dated 9/30/14, indicated R32 had limited physical mobility with the goal of increasing mobility by ambulating with nursing to and from the dining room and bathroom. The CP directed the staff to ambulate R32 with SBA of 1 staff using 2 wheel walker. The nursing assistant care plan, dated 10/29/14, under the ambulation section was blank. When interviewed on 10/29/14 at 9:45 a.m., Licensed practical nurse (LPN)-A explained that when a resident was to be ambulated by nursing following PT, there should be an ambulation record. LPN-A stated there was no ambulation record to indicate nursing was ambulating R32 and agreed that the care plan directed staff to ambulate R32, but staff were not doing so. Interview with the physical therapist (PT)-C on 10/29/14 at 9:57 a.m., stated there was no documentation of R32 ambulating on the nursing station. PT-C went on to explain that R32 was very inconsistent with ambulating, so PT goes up everyday to assist the resident with ambulation. PT-C stated that nursing should still be ambulating R32 as directed. Interview with registered nurse (RN)-A on 10/29/14 at 10:53 a.m., RN-A explained that usually PT gave clearance for nursing to ambulate a resident and did not think PT had given clearance for R32 to ambulate on the floor. RN-A stated being unaware of the communiqué from PT or of the care plan directions for staff to ambulate R32. Interview with NA-C on 10/29/14 at 11:03 a.m. revealed R32 usually ambulates to the bathroom,	F 311		

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F 311	Continued From page 7 however, it is not documented. NA-C indicated there should be an ambulation record in the ambulation book. Review of the facility's undated policy and procedure titled, Ambulation, directed staff to check the ambulation record or to check with the charge nurse as to the type of walking activity, and to document in the ambulation record as directed by the charge nurse or therapy.	F 311		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		10/31/14

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F 356	Continued From page 8 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required nurse staffing information to include the actual hours worked by licensed and unlicensed staff for 3 of 4 days reviewed. This practice had the potential to affect family, staff, visitors and all 75 residents residing at the facility. Findings include: Observations of the posted staffing forms dated 10/27/14, 10/28/14 and 10/29/14, lacked documentation of the actual shift hours worked by licensed and unlicensed staff at the facility. During the initial facility tour on 10/27/14, at 11:45 a.m., the facility staffing posting dated 10/27/14, was observed posted in the lobby wall by the first floor nursing station. The form identified the name of facility, the date, census, number of licensed and unlicensed staff, total number of hours and identified the shifts as Day, Evening and Night. There were no actual shift hours posted. Observations of nursing staff posting forms on 10/27/14, 10/28/14 and 10/29/14, noted the actual shift hours worked for the licensed and unlicensed staff was lacking. During an interview with the Director of Nursing (DON) on 10/29/14 at 2:44 p.m., the DON verified	F 356	St. Anthony Park Home will post the actual hours worked by the staff covered under this regulation. The administrator will monitor this tag on a weekly basis.	

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F 356	Continued From page 9 the actual shift hours worked by nursing staff at the facility for three days was lacking. Further stated, not being aware that actual shift hours staff worked needed to be on the staff posting. The policy and procedure for the staffing posting was requested, but not provided.	F 356		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food at an appropriate temperature for 8 of 28 residents (R19, R27, R103, R31, R44, R18, R74, R32) who were served in the third floor dining room. Findings include: During observations of the second floor dining room on 10/27/14, at 12:30 p.m. there were complaints expressed regarding the temperature of the food served. At 12:35 p.m. R19, R27 and R103 were the last table to be served. When asked if the food was hot, all three residents expressed, "No!" R103 further stated, "The food is often just luke warm. We complain all the time, they don't hear us anymore" R27 expounded, "the food is not hot," but prefers not to send it back to be re-heated because, "It happens so often, and	F 364	St. Anthony Park Home will ensure that resident meals are served at or above the temperature specified in our policy. Different foods will have different required temperatures. The food serving procedures are also being adjusted by purchasing additional equipment, such as insulated lids and bowls and by using different methods of keeping the food warm. All dietary department employees will attend an in service regarding this citation. Monitoring of food temperatures will be accomplished by sending an extra tray to the floor each day and that tray will then be temped, after the last resident tray is served. The dietary manager or cook will monitor the recording of these temperatures. The RD will review these logs two times each month to ensure	12/5/14

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F 364	Continued From page 10 it doesn't do any good to complain." R19 stated, "The food is never very hot, they warm it up if you ask them to, but you have to wait for that to happen." R31 and R44, who sat at another table were interviewed on 10/27/14 at 12:42 p.m. and expressed dissatisfaction with the food not being hot enough, and explained that frequently staff are told of concerns and that on numerous occasions dissatisfaction with food being luke warm has been communicated. Both residents stating having complained so much with no results. R44 stated, "Why bother complaining, nothing happens and no one lets us know if it will get fixed so we have just given up. It is just too much effort". R31 was observed to shake her head yes in validation of R44's statement and commented, "That's right!" During interview with R18 on 10/27/14 at 4:40 p.m. regarding the food quality, indicated that once in awhile the food hasn't been hot - especially the hot dogs. During interview with R74 on 10/27/14, at 6:41 p.m., R74 shared that frequently reports were made to staff regarding concerns with the vegetables, especially the overcooking of beans and carrots. R74 stated having communicated with the food service manager (FSM) regarding concerns about the food. Interview with R32 on 10/27/14 at 6:59 p.m., R32 stated, "The people really have to speak up for the staff to hear them. I noticed in the dining room tonight, people asking for things and it is like the staff don't hear them."	F 364	compliance with this citation. The purchasing of the additional equipment will be completed as soon as possible. The estimated delivery of the items will be early January 2015 at the latest.	

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F 364	Continued From page 11 On 10/27/14, at 5:28 p.m., observations of the food preparation for the evening meal, was conducted in the kitchen. The temperature of the cheddar cheese soup at the beginning of serving was 182 degrees Fahrenheit (F). The 4 gallon size container of hot soup was removed from the stove top burner and set on the counter (non heated surface) for serving. The first bowl of cheddar soup was dished at 5:34 p.m. The first floor cart was being prepared for 15 residents and was taken up to the unit at 5:43 p.m. The first of two carts for the third floor, containing 20 resident trays, was filled and delivered to the third floor at 5:47 p.m. Cook (C)-A took the temperature at surveyor request of the cheddar soup and the temperature was 142 degrees F. The temperature dropped 40 degrees in 19 minutes of sitting on the unheated counter. C-A took a second pan of cheddar soup off the stove top burner and the temperature of this soup was 190 degrees Fahrenheit. C-A used this soup to finish the second cart for the remaining 8 residents on third floor and to fill the two carts for the 30 residents on second floor. Observation of the food preparation for the noon meal on 10/28/14, at 11:09 a.m., there was cream style corn bubbling on the stove top. C-C turned the creme style corn off from the heat source at 11:20 a.m. and left the open pan on the stove top. At 11:45 C-C turned the heat source on the stove top back on for the creme style corn. Surveyor requested the temperature of the corn, which C-C temped at 120 degrees F. On 10/28/14, at 11:53 a.m., C-C began the tray line set up. C-C removed a pan of sliced ham in liquid from the oven. The temperature was 140 degrees F and C-C said it must be heated higher and put back in the oven. C-C removed a second pan of ham	F 364		

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F 364	Continued From page 12	F 364		

slices in liquid from the oven and this temperature was 198 degrees F. This pan of ham was set on an unheated counter top for serving. Next the sweet potatoes were removed from the oven and set on the unheated counter top. The temperature of the sweet potatoes was 180 degrees F. A large 4 gallon size pan containing cauliflower was removed from the stove top and set on the unheated counter. The temperature of the cauliflower was 190 degrees. A pan of ground ham was removed from the oven and set on the stove top and temped at 178 degrees F. A pan of puree sweet potatoes was removed from the oven and set on the stove top and the temperature was 160 degrees F.

During observation of the third floor food carts on 10/28/14, at 12:49 p.m., both carts were delivered to the unit at the same time. Meal trays were passed to the residents by 1:05 p.m. The surveyor test tray for mechanical soft diets was tempted for food temperatures by the FSM. At 1:05 p.m. the sweet potato's were 95 degrees F, the chopped ham was 90 degrees F and the vegetable cauliflower was 110 degrees F. The surveyor test tray for regular diets was tempted for food temperatures by the FSM. At 1:06 p.m., the sweet potatoes were 108 degrees F, sliced ham in broth was 130 degrees F, and the cauliflower was 110 degrees F. Surveyor tasted the food which had good flavor but the temperature palatability was luke warm.

During an interview with the FSM on 10/28/14, at 2:00 p.m., regarding recording food temperatures at the time of service, revealed there was no place to record the ground or puree food items on the form. A review of the forms, titled, Serving Temp Check Form, for the month

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	245063	A. BUILDING _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 13 of October 2014, revealed there were no temps taken if more than one soup was served and there were no temperatures of the ground/puree food items. A review of the Sept. 2014 policy titled," Food Temps" directed, All Hot foods should be at 165 or higher. Another policy dated August 2014 and titled, Temperature Policy, read, 1. Meats 165 or higher. 2. Vegetables 165 or higher 3. Potatoes 165 or higher 4. Soups 180 or higher, if doesn't reach the proper temp, discard 5. Hot cereals 180 or higher 6. Eggs 165 or higher and then the policy read, Should be at these temps when they leave the kitchen. When interviewed the FSM stated "We like everything to be over 165 degrees." The FSM verified the cooks would need further training on correct food temperatures.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		12/5/14

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F 371	Continued From page 14 by: Based on observation, interview and document review, the facility failed to ensure cheddar cheese soup stored in a refrigerator was properly and timely cooled/chilled. This had the potential to affect all 75 residents in the facility. Findings include: During the kitchen observation on 10/27/14, at 5:30 p.m. cheddar cheese soup was served as the main course to the residents. At 7:20 p.m., there were three half gallon size containers, three fourths full, in the walk in refrigerator. The containers of soup were tightly covered, warm to the touch, and on the third shelf of the cooler. The cook who prepared the soup had left for the day. Interview on 10/28/14, at 11:27 a.m. with the food service manager (FSM) indicated the cooks were to cool potentially hazardous foods properly according to the procedure. There was to be a record of the time and temperature to prevent foodborne illness by ensuring foods are cooled properly. The FSM verified there had been a breach in the system because the cooks are not documenting the time and temperature and have not ensured food is cooled from 140 degrees to 70 degrees within 2 hours. The FSM stated, "This has to be thrown out." pertaining to the three containers of cheddar soup. During interviews with 3 cooks on 10/28/14, at 11:30 a.m. Cook (C)-B, C-C, and C-D verified they did not realize temperatures were to be taken and recorded to ensure the proper chill down time and to ensure foods are cooled properly to prevent food borne illness.	F 371	St. Anthony Park Home will properly chill hot prepared food that is to be stored in the refrigerator. Dietary will be in serviced on the proper procedure for chilling and storing food and the requirement to record the time and temperatures of the food being stored. The dietary manager, or cook, will monitor the "chill" sheets on a daily basis. The RD will review the results two times per month to ensure compliance with this citation.	

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F 371	Continued From page 15 A review of the undated facility procedure titled, Policy for Soup Temperature Before Placing in Cooler, did not address other potentially hazardous foods that needed to be cooled properly. The FSM verified on 10/28/14, at 1:00 p.m., that the staff had not been keeping a record of temperatures.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		12/5/14

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F 441	Continued From page 16 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow policies to ensure proper infection control techniques were followed related to storing reusable ice packs with food, in freezers on all three floors affecting residents that stored or ate food from the freezers, and failed to ensure gloves were applied during insulin administation for 1 of 1 resident (R75) reviewed for insulin administration. Findings include: Policy and procedure titled "Application of ice pack" updated 10/30/14, reads, "Reusable packs are to be disinfected and placed in a freezer designated for resident ice packs. Ice packs are not to be commingled with non-treatment items." On 10/27/14, at 12:32 p.m., during random observation of second floor's freezer, 3 blue unlabeled ice packs were observed to be stored in the refrigerator freezer next to 46 fl oz cranberry juice, 19 ice cream cups, a variety of unlabeled, undated food items and a dinner plate with no date or label. On 10/27/14, at 12:55 p.m., during observation on third floor's refrigerator's freezer, 4 unlabeled large ice packs were observed to be stored in the	F 441	St. Anthony Park Home will not store ice packs in a freezer that also contains food for residents. Ice packs for the residents are now stored in a separate freezer located in a nursing area. Gloves will be applied by nurses during insulin administration. Licensed Nurses and Nursing Assistants will be required to acknowledge their understanding of both of these policies via a written in service. The freezers located in the resident areas will be monitored daily by nursing, or housekeeping to ensure the ice packs are not being stored in them. The nurses will be monitored by nursing administration two times per week to ensure that gloves are applied during insulin administration. The DON will review the monitoring checklists for both of these issues on a weekly basis to ensure compliance with this citation.	

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F 441	Continued From page 17 refrigerator freezer with 23 - 4 fl. oz. of ice creams cups, unlabeled food items and 2 bottles of water labeled S-B. On 10/27/14, at 1:23 p.m. during observation of the refigerator behind the nursing station on first floor, 2 blue unlabeled large ice packs were observed to be stored in the refrigerator freezer with 21 - 4 fluid ounces ice cream cups. During a tour with the director of nursing (DON) on 10/27/14 at 1:11 p.m., the DON verified ice packs and food were stored together on all three floors and stated that staff, including physical therapy, will be educated on the storage of the ice packs. The facility policy and procedure titled: Insulin injection administration procedure. Dated, 4/20/12, directed, "8. To administer the medication: Put on gloves. Cleanse the injection site with an alcohol wipe." On 10/28/14, at 11:40 a.m., licensed practical nurse (LPN)-B was observed to not don gloves before and during insulin administration for R75. During the medication pass with LPN-B on 10/28/14 at 11:40 a.m,. LPN-B was observed to administer R75's insulin. LPN-B wiped the area with alcohol and administered the insulin by injection. LPN -B did not wear gloves. During an interview with LPN-B on 10/28/14 at 11:44 p.m., when asked if she usually wore gloves with insulin administration, LPN-B stated, "I usually don't wear gloves when I give insulin." Interview with DON on 10/29/14 at 2:46 p.m., stated the expectation was, "nurses should wear	F 441		

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F 441	Continued From page 18 gloves when giving insulin".	F 441		

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	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/28/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St Anthony Park Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/20/2014

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The St Anthony Park Home was constructed at three different times. The original building was built in the 1900s, is 3 stories, with a basement and was determined to be of a Type II (111) construction with a wood frame roof system that meets the exception to "The Life Safety Code" NFPA 101 (2000 edition) Section 16.1.6.2. In 1960 an addition was constructed to the west of original building, which was 1-story, with a basement, and was determined to be Type II (111) construction. In 1999 a 2nd and 3rd floor were constructed over the 1960 addition that are separated with a 2 hour fire barrier from the 1900 original building and are Type II(111) construction. The building is divided into 11 smoke zones (3 each level except the basement) by at least 1 hour fire barriers. An automatic sprinkler system is installed throughout the building. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces and in all the sleeping rooms of the 1999 additions.	K 000		

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	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/28/2014**

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K 000	Continued From page 2 Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code. The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 75 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:00 AM and 01:00 PM on 10/28/2014, based on review of available	K 050	Fire drills are now scheduled at different times during each of the three daily shifts. From a time standpoint the shifts are roughly divided in thirds and each of those thirds will have a drill at a minimum of once per year.	11/17/14

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K 050	Continued From page 3 documentation it was reveled that: 1) Fire drills were not varied throughout the shift on all shifts: Day shift - all drills conducted during 9:00 to 10:00 hour. Evening shift - all drills conducted during 3:00 to 4:00 hour. Night shift - all drills conducted during the 5:00 hour. This deficient practice was verified by Maintenance Supervisor (GA).	K 050		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to maintain the fire alarm system in accordance with NFPA 72, 1999 Edition. This deficient practice could affect all occupants including patients, staff and visitors. Findings include:	K 052	The fire alarm system will be tested on a monthly basis. The administrator will monitor this on a monthly basis.	11/17/14

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K 052	Continued From page 4 On facility tour between 09:00 AM and 01:00 PM on 10/28/2014, based on review of available documentation it was reveled that there was no documentation that the fire alarm had not been tested on a monthly basis in January, April, May, July and August of 2014. Fire alarm is tested only during fire drills. This deficient practice was verified by Maintenance Supervisor (GA).	K 052		
K 067 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the ventilation system in accordance with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 09:00 AM and 01:00 PM on 10/28/2014, based on review of available documentation it was reveled that there was no documentation that smoke/fire dampers had been tested and inspected every four years.	K 067	St. Anthony Park Home will test the smoke/fire dampers by December 4, 2014 and will test them every four years. The Maintenance director will monitor compliance with this tag.	12/4/14

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K 067	Continued From page 5 This deficient practice was verified by Maintenance Supervisor (GA).	K 067		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 09:00 AM and 01:00 PM on 10/28/2014, based on review of available documentation it was reveled that there was no documentation that the generator had not been tested under load in August of 2014. This deficient practice was verified by Maintenance Supervisor (GA).	K 144	St. Anthony Park Home will test the generator under load each month. Compliance with this tag will be monitored by the administrator on a monthly basis.	12/4/14

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 13, 2014

Mr. John Barker, Administrator
St Anthony Park Home
2237 Commonwealth Avenue
Saint Paul, Minnesota 55108

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5063025

Dear Mr. Barker:

The above facility was surveyed on October 27, 2014 through October 30, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
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