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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0H5S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00522

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245267**

2. STATE VENDOR OR MEDICAID NO. (L2) **369742800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ANTHONY HEALTH CENTER**
(L4) **3700 FOSS ROAD NORTHEAST**
(L5) **ST ANTHONY, MN** (L6) **55421**

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 **12/21/2016** (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 **150** (L18)

13.Total Certified Beds **150** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(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 :
Gloria Derfus, Unit Supervisor 01/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/10/2017 (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 **07/01/1984** (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) **00**

VOLUNTARY
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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245267

January 10, 2017

Ms. Mary Yaeger, Administrator
St Anthony Health Center
3700 Foss Road Northeast
St Anthony, MN 55421

Dear Ms. Yaeger:

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 14, 2016 the above facility is certified for:

150 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 150 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 9, 2017

Ms. Mary Yaeger, Administrator
St. Anthony Health Center
3700 Foss Road Northeast
St Anthony, MN 55421

RE: Project Number S5267028

Dear Ms. Yaeger:

On November 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 9, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 4, 2017 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 November 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 14, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 9, 2016, effective December 14, 2016 and therefore remedies outlined in our letter to you dated November 22, 2016, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245267 Y1	A. Building B. Wing Y2	12/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0258	Correction	ID Prefix F0312	Correction	ID Prefix F0356	Correction
Reg. # 483.15(h)(7)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.30(e)	Completed
LSC	12/14/2016	LSC	12/14/2016	LSC	12/14/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/14/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	01/09/2017	18623	12/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/9/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245267	A. Building 01 - MAIN BUILDING 01 B. Wing	1/4/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 12/14/2016	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	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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	1/9/2017	19251	1/4/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/9/2016

☐ 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: 0H5S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00522

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245267**

2. STATE VENDOR OR MEDICAID NO. (L2) **369742800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ANTHONY HEALTH CENTER**
(L4) **3700 FOSS ROAD NORTHEAST**
(L5) **ST ANTHONY, MN** (L6) **55421**

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 **11/09/2016** (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 **150** (L18)

13.Total Certified Beds **150** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(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 :
Glenora Souther, HFE NE II 12/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/04/2017 (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)

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3. Both of the Above :
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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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 23, 2016

Ms. Mary Yaeger, Administrator
St. Anthony Health Center
3700 Foss Road Northeast
St. Anthony, MN 55421

RE: Project Number S5267028

Dear Ms. Yaeger:

On November 9, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the November 9, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5267071 that was found to be unsubstantiated.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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 19, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 February 9, 2017 (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 May 9, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	11/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. In addition during the recertification survey complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5267071 was completed. The complaint was not substantiated.	F 000		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comfortable sound levels were maintained for 1 of 1 resident (R132). Findings include:	F 258	St. Anthony Health Center (SAHC) makes its best effort to operate in full compliance with state and federal law. Nothing included in this plan of correction is an admission otherwise.	12/14/16

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

Electronically Signed | 12/01/2016

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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	245267	A. BUILDING _____ B. WING _____	11/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 1 During an interview with R132 on 11/6/16, at 6:48 p.m. loud TV noise could be heard from the hallway outside R132's room with the door closed before writer entered room for initial interview. Upon entering R132's room he held one hand behind his ear and pointed toward roommate's TV with the other hand and stated; " It is loud like that all the time " both R132 and interviewer had to speak very loud to be heard due to the TV volume being so loud. R132 further stated he had told staff about it but nothing had been done to fix the noise issue yet. On 11/8/16, at 12:24 p.m. as the surveyor started walking down the 2 south hallway where it was noted that a television (TV) volume was turned up very loudly. As the surveyor reached a resident's room it was noted the TV noise was coming from R171 side of the room. The surveyor looked into the room and observed only one resident in the room R171 who was asleep in his bed. The loud TV could be heard very clearly three doorways away. During an interview on 11/8/16, at 2:01 p.m. R132 was lying in his bed with his eyes open. R132 said, "the TV is too loud, [pointing to his roommate ' s side of the room R171]. " R132 stated he had told staff about the TV being too loud but nothing had been done about it. R132 stated he would like to be moved to a different room if possible. R132's care plan dated 9/21/16, indicated R132 needs assistance in adjusting to long term care with a goal to show no mood or behavior decline. Staff interventions are to provided measures to promote adequate sleep, minimize outside noise and encourage routine bedtime.	F 258	SAHC has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that SAHC may contest the merits and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. Please accept this plan of correction as SAHC's allegation of substantial compliance. F258 Maintenance of Comfortable Sound Levels 1. Resident R132 room change offered and completed. SS and Nursing have followed up and he is satisfied in new room and has no further noise complaints. Resident R132 Care Plan has been reviewed and updated as needed. 2. Resident R171 has been provided with earphones. Resident R171 Care Plan has been reviewed and updated as needed. 3. Staff will receive education on ensuring comfortable noise levels for residents. 4. Residents in surrounding rooms will be interviewed about noise levels weekly until the next QA&A committee meeting	

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F 258	Continued From page 2 A few minutes later at 2:02 p.m. a nursing assistant (NA)-A was interviewed and stated R132 had complained to her about the TV being too loud a few weeks ago and she reported it to the nurse in charge. NA-A stated R171 was to wear TV headphone but he did not like to wear them, " I can go and ask [R171] if he would put on the headphone or turn down the TV. " On 11/8/16, at 2:04 p.m. two licensed practical nurses (LPN)-D and (LPN)-E both stated that 2 south was their regular floor to work and both are familiar with R132. Both LPN-D and LPN-E explained when R132 first was admitted he complained about his roommate's TV being too loud and we referred the complaint to our nurse manager (LPN)-C. LPN-D stated R132 was having a hard time sleeping at night due to R171 TV being too loud so now the TV was turned off during the night. The same day at 2:07 p.m. an interview with R171 was conducted in his room. R171's TV sound was turned up very loudly and could be heard down the hallway. R171 stated he had headphone but they are worn out. At 2:08 p.m. LPN-C was interviewed and stated he was aware that R132's roommate's TV was too loud for him. LPN-C explained he first heard of the issue about the loud TV of R171 2-3 days after R132 moved into that room. We provided R171 with some headphones to wear while watching TV and R171 was willing to wear the headphones when R132 was in the room. LPN-C said, "I checked with him [R132] the next day and he [R132] stated the night was much better. " LPN-C verified he only followed up the next day	F 258	12/20/16. 5. Grievance forms and investigation will be completed with any resident concern about noise level. 6. Residents will be asked about noise level at the monthly resident council meetings. The facility QA&A committee will review completed audits, grievance forms, and resident council minutes for any concerns and further recommendations. 7. The Executive Director remains responsible for compliance with this requirement to ensure to ensure comfortable sound levels in the facility.	

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F 258	Continued From page 3	F 258		

but had not check after that day to see if the issue was resolved per R132 satisfaction. When LPN-C was asked if he ever asked R132 if he would like another room he replied, "No. " LPN-C stated R132 had not complained to him nor have staff reported to me about the TV volume still being an issue "so I figured the problem was fixed. "

That same day at 2:19 p.m. LPN-C went to R171's room were the TV volume was turned up loudly. LPN-C asked R171 were his headphone are, R171 said, " I don't know I can't get out of bed, I'm in my bed all day long. " LPN-C continued to pull open R171 dresser drawers and found 2 pairs of headphone in the bottom drawer. When LPN-C was asked how can R171 reach them to wear them, he replied, "Good question. " Immediately when LPN-C pulled out the two pairs of headphone R171 said, " I don't want to wear them, I don't like them. " The LPN-C went over to R132 side of the bed and asked if he wanted to change rooms. R132 said, "Yes, the TV is too loud. " As the LPN-C left the room and reached the dining room the LPN-C verified he still could hear R171 ' s TV into the dining room.

On 11/9/16, at 7:15 a.m. R132 was moved to a different room. R132 explained he was happy with his room change and "no more loud TV. " R132 said, "I got a good night sleep because yesterday the TV was too loud."

A review of R132 ' s nursing note indicated on 10/19/16, at 1:15 p.m. R132 was moved to room 231 in with R171 due to change in his long term care status. On 10/28/16, at 2:55 a.m. LPN-D transcribed a nursing noted indicating R132 "made a comment about roommate's TV is too loud."

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F 258	Continued From page 4 A policy and procedure was requested but not provided.	F 258		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided for 1 of 1 resident (R154) reviewed for activities of daily living (ADLs) and who depended on staff for nail care. Findings include: During an observation on 11/6/16, at 3:04 p.m. R154 was in her wheelchair (w/c) in the dining room watching a television program. The surveyor notice all of R154 fingernails on both hands were long, jagged, uneven and in need of trimming. In addition, R154 fingernails had a dark black substance embedded under each of her nails. During an interview on 11/7/16, at 2:25 p.m. R154 was lying in bed, her fingernails continued to look the same as on 11/6/16. When R154 was asked when her nail were last cut, she held up her hand looked at her nails and said, "I just did them myself."	F 312	F312 ADLs 1. Resident R154□s care plans and NAR assignment sheets have been reviewed and revised as needed to reflect current ADL abilities. 2. Other residents will have their ADL care plans reviewed and updated as needed with each quarterly, annual, or significant change of condition MDS. 3. Staff will receive training regarding bathing and nail care procedures. 4. Facility leadership will conduct Bathing and Nail care audits 3x/week until the next QA&A committee meeting 12/20/16. 5. The Director of Nursing will review the completed audits and bring any identified concerns to the facility QA&A committee for review and further recommendations. 6. The Director of Nursing remains responsible for compliance with this requirement that residents receive the necessary services to maintain ADLs.	12/14/16

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F 312	Continued From page 5	F 312		

R154 was observed on 11/8/16, at 7:13 a.m. sitting in the dining room waiting for breakfast. R154's fingernail continued to be long, dirty and jagged as they were on 11/6/16.

R154's care plan dated 11/1/16, indicated R154 had self-care deficit for grooming related to (r/t) limited mobility and weakness. R154 had an alteration in her thought processes r/t her diagnosis of dementia and diabetes. R154 required one staff assistance with grooming and her goal was to be clean and well-groomed daily. Intervention for staff were to assist with grooming.

During an interview on 11/8/16, at 7:50 a.m. the registered nurse (RN)-A explained she has created one bath schedule sheet that is kept in the shower room. RN-A and the surveyor both reviewed the shower schedule as it indicated that R154 was to receive a shower on every Saturday on the PM shift. The sheet reviewed had R154 name but nothing was filled in from staff of when a shower/bath was given nor if any nail care was provided. RN-A stated this sheet is new and I don't think the staff know how to fill it out correctly. RN-A confirmed the nurses will do a skin check once a month on each resident and if a resident is a diabetic the nurse will provide nail care as they see fit. RN-A verified that when a nurse provides nail care to a resident there is no placed for the nurse to document that nail care was provided "I just expect them to do it."

During an interview the same day at 8:29 a.m. licensed practical nurse (LPN)-A stated the nursing assistants are responsible for cutting resident nails and grooming after each bath if needed. LPN-A stated if a resident is a diabetic

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F 312	Continued From page 6	F 312		

then the nurse will provide nail care. LPN-A explained I know which of my residents are diabetic so I will cut their nails when needed. LPN-A verified after she had provided nail care there is no place for her to document that it was done.

During an interview the same day at 8:33 a.m. (LPN)-B explained if a resident is a diabetic then nursing it to provide nail care after the resident has taken a shower. LPN-B stated there is a check list we follow after a resident had a shower where we can document that nail care was provided. LPN-B produced a sheet of paper titled "Weekly Body Audit." LPN-B verified on the sheet there was not a spot for staff to fill in if nail care was provided, LPN-B said, "I will sometimes write a note over in the margin that nails were trimmed."

During an interview on 11/8/16, at 9:47 a.m. RN-A and the surveyor both when to R154's room. RN-A observed R154's nails on both hands and said, "Her nails were longer than they should be and had dirt underneath them." RN-A explained there is no facility policy for nursing staff to document when nail care were last done, "so we have no way to track back to see when nail care was last done." RN-A verified she expects her staff to provide nail care when needed after the resident had their bath/shower.

R154's Weekly Body Audit was reviewed for two months and lack any documentation that nail care was provided. A review of R154 treatment sheet for 11/2016, indicated R154 nail care was last provided on 11/6/16 from (LPN)-F.

R154 was observed on 11/9/16, at 7:50 a.m.

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F 312	Continued From page 7 sitting in her w/c waiting for breakfast. R154's nails were trimmed, smooth and contained no dirty. R154 said, "Some guy cut them yesterday and they feel much better." A follow-up interview on 11/9/16, at approximately 8:00 a.m. RN-A verified R154's treatment sheet on 11/6/16, was signed off by LPN-F as providing nail care to R154. RN-A verified if any nail care was provided by LPN-F on that day it was not done adequately because on 11/8/16, R154 continue to have long nails and dirt under them. RN-A verified LPN-F was the one who cut R154 nails yesterday. The facility's policy and procedure titled "Nail Care" dated 6/27/12, indicated staff to soak residents hands in warm soapy water, clean under nails and cut or file nails straight across if needed and if a resident is a diabetic nurse must do nail care.	F 312		
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.	F 356		12/14/16

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F 356	Continued From page 8 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. 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 ensure the report of nursing staff directly responsible for resident care was updated daily to reflect actual hours worked. This practice had the potential to affect all 132 residents who resided in the facility, family and visitors who wished to view the information. Findings include: During the initial tour on 11/6/16, at 11:30 a.m. the unlabeled daily nurse staffing posting was observed posted on the wall in the facility's main lobby. The posting included the facility name, resident census of 134, hours of labor for registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (NAs). The posting was dated 11/4/16, which was two days prior.	F 356	F356 Posted Nurse Staffing Information 1. The facility□s policy on posted staffing information was reviewed and remains appropriate. A step by step procedure for posting staffing information was developed for the Nurse Supervisors. 2. Nursing Staff will receive training regarding posted Nurse Staffing Information. 3. Nursing Leadership will audit the posted nurse staffing information 3x/week until the next QA&A committee meeting 12/20/16. 4. The Director of Nursing will review the completed audits and bring any identified concerns to the facility QA&A committee for review and further recommendations. 5. The Executive Director remains responsible for compliance with this	

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F 356	Continued From page 9 On 11/8/16, at 6:45 a.m. surveyor observed staff posting on wall dated 11/7/16. On 11/6/16, at 12:04 p.m. registered nurse (RN)-B verified posting was dated 11/4/16, and the census listed was 134. During interview on 11/6/16, at 12:06 p.m. office manager stated current census was 132 in the building and five residents on leave of absence for a total of 137. During interview on 11/9/16, at 10:43 a.m. director of nurses (DON) said the staffing coordinator left it in the supervisor ' s book to update and post. The DON stated it should be posted by the night supervisor before 6 a.m. when the day shift starts. The staff do not take residents who are on leave of absence out of the total census. I expect the staff to post the form every morning including weekends. Nurse Staffing Information policy dated 9/11/15, instructed staff "it is the policy of this facility to post nurse staffing information on a daily basis. 1. The nurse staffing information will contain the following information: a. facility name b. The current date c. Facility's current census d. The total number and actual hours worked by the following staff: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides 2. The facility will post the nurse staffing daily at the beginning of each shift."	F 356	requirement that Nurse Staffing is posted.	
F 465	483.70(h)	F 465		12/14/16

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F 465 SS=E	Continued From page 10 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 7 of 7 residents (R26, R78, R82, R175, R188, R200, R248) rooms were maintained in good repair. Findings include: The maintenance director (MD) was interviewed regarding the facility's preventive maintenance plan on 11/9/16, at 9:00 a.m. The MD explained he utilized a software program were it indicates when vents, ducts and more mechanical work need schedule maintenance. The MD verified the software does not provide daily/monthly/years maintenance for room repairs. During an environmental tour with the MD, director of environmental services (DES), administrator intern (AI) and administrator in training (AIT) on 11/9/16, at 9:01 a.m. the following was observed: 1) During observation of incontinance cares on 11/8/16, at 7:32 a.m. R175 reached into the toilet and started washing his bottom with his left hand. Licensed practical nurse (LPN)-G worked with R175 to get hand out of the toilet and rewashed R175 hand. LPN-G had resident stand up and nursing assistant (NA)-B washed stool off R175's	F 465	F465 1. 7 out of 7 rooms were immediately repaired. 2. Each resident room in the facility was reviewed for repairs needed. 3. The preventative maintenance program has been revised to include quarterly audit of each resident room and common area. 4. Staff will be re-educated on the reporting maintenance needs/work orders. 5. The facility QA&A committee will review completed audit results and make further recommendations. 6. The Executive Director remains responsible for compliance with this requirement to ensure resident rooms are in good repair.	

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bottom. LPN-G said, "We have to be careful to make sure his hands are washed well. He will wipe the stool from his hands, on the walls and doors in his room and the hall way."

R175's significant change Minimimum Data Set (MDS) dated 8/24/16, indicated R175 was severly cognitively impaired with worsoning behaviors including physicalbehaviors toward others anad wandering. R175 MDS indicate R175 diagnoses included dementia, anxiety and history of a stroke.

R175's bed was pushed up against the wall were immediately upon entering the room the wall had three visible large stained areas. The areas looked as if something was splashed or thrown again the wall with dried water lines/marks that ran down the entire length of the wall below the mattress level. There was other areas on the wall that contained dried food and R175's bathroom door had larges gouges taken out of it that ran down the side of the door to the floor. The DES, AI and AIT all verified R175 has a history of removing his incontinent pad after a bowel movement and smearing it on the walls.

2) R26's wall had several long large black marks that ran vertical along the wall for about 4 feet and were about 1 foot above the mattress level. One wall had a hole that was repaired, however it was never repainted to match the rest of the walls color. The floor at the foot of R26's beds had several long dark black gouges taken out of the tiles.

3) R82's wall under the light switch had two gouges taken out of it where the plaster was showing and a long scuffed mark that removed

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	245267	A. BUILDING _____ B. WING _____	11/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 12	F 465		

the paint from the wall. R82's bathroom door outside and inside had gouges along the edges that ran horizontally and vertical.

4) R188's wall had two gouges taken out of it where the plaster was showing. R188's bathroom door outside and inside had gouges along the edges that ran horizontally and vertical.

5) R200's wall had a hole that was repaired, however the wall was never repainted to match the green wall.

6) R248's bathroom had two areas by the toilet with ripped drywall and gouges taken out of the wall. The four walls inside the room had multiple gouges by the resident ' s bed and nightstand. A resident in the room stated he just moved in a few days ago and the walls had the gouges in them.

7) R78's had a base board that ran horizontal across the wall about 1 foot above the mattress level. The base board had chipped, peeling, missing and scratch paint on it. R78 stated some lady came in here and started painting but then never came back to finish it up.

All that were present on the tour verified that the rooms were not in good repair and the residents should not have to live in rooms unpainted, marks on the floors and walls in disrepair. The MD explained his staff goes around once a year to do a full sweep of the rooms to see which rooms need repairing. The MD stated he has a list of rooms that needed attention and just started to get to it in the last two weeks. The MD was not able to provide the list of room that needed repair or what the maintenance department was working

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F 465	Continued From page 13 on. The MD verified general painting was not in the preventative maintenance plan, we rely on staffing to let us know if a room need fixing or painting. A policy and procedure was requested but not provided.	F 465		

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	245267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/09/2016**

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

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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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on November 09, 2016. At the time of this survey, St. Anthony Health Center 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 2012 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 (K-TAGS) 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		12/01/2016

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 and Angela.Kappenman@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. St. Anthony Health Center is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1997, an addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 150 beds and had a census of 138 at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
K 353 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain the sprinkler system in accordance with LSC (12) edition section 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice would only affect minimum residents. Findings include: On facility tour between the hours of 9:00 AM and 12:30 PM on 11/09/2016, it was observed in the kitchen walk-in cooler that a sprinkler head bulb had changed colors from red to clear not in accordance with NFPA 25.	K 353	K353 1. Sprinkler in the kitchen walk-in cooler was replaced immediately. 2. Each sprinkler head bulb color in the facility was audited for its functionality. 3. The facility QA&A committee will review completed audit results and make further recommendations. 4. The Executive Director remains responsible for compliance with this requirement.	12/14/16

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K 353	Continued From page 3 This deficient practice was observed by the Maintenance Supervisor at the time of inspection.	K 353		