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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9FL6

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 **01/16/2015** (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:
X 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 :
Magdalene Jares, HFE NE II 01/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/21/2015 (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
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)
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
01/07/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5267

January 21, 2015

Ms. Marcia Lindig, Administrator
St Anthony Health Center
3700 Foss Road Northeast
St Anthony, Minnesota 55421

Dear Ms. Lindig:

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 30, 2014 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,

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

January 21, 2015

Ms. Marcia Lindig, Administrator
St Anthony Health Center
3700 Foss Road Northeast
St Anthony, Minnesota 55421

RE: Project Number S5267026

Dear Ms. Lindig:

On December 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 21, 2014. 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 January 16, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 31, 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 November 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 21, 2014, effective December 30, 2014 and therefore remedies outlined in our letter to you dated December 5, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have 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

Enclosure
cc: Licensing and Certification File

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
245267	A. Building B. Wing	1/16/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **12/30/2014**
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/30/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/30/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/30/2014**
ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/30/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/30/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	01/21/2015	32982	01/16/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/21/2014

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 A. Building B. Wing	(Y3) Date of Revisit
245267	01 - MAIN BUILDING 01	12/31/2014

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	12/30/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 01/21/2015	**Signature of Surveyor:** 12424	**Date:** 12/31/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 11/19/2014		**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: 9FL6

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 **11/21/2014** (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 **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

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
	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 :
Magdalene Jares, HFE NE II 12/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/07/2015 (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)
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

Certified Mail # 7010 1060 0002 3051 5003

December 5, 2014

Ms. Marcia Lindig, Administrator
St Anthony Health Center
3700 Foss Road Northeast
St Anthony, Minnesota 55421

RE: Project Number S5267026

Dear Ms. Lindig:

On November 21, 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 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.

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;

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 55108-2970

Telephone: (651) 201-3792
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 31, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 21, 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 May 21, 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 a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	11/21/2014

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	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. 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.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 5 residents (R271, R114, R236, R116 and R26), who verbalized complaints, were provided with a dignified dining experience, free from repetitive loud noises, yelling and expletives. This had the potential to affect all 26 residents who routinely ate in the 2-North dining room. The facility also failed to provide dignified dining assistance, related to standing while feeding, for 2 of 36 residents (R224 and R287), who were dependent on staff assistance for eating. Findings include:	F 241	R236 has been discharged from the facility. The care plans and NAR assignment sheets for R271, R114, R116, R26, R224, and R287 have been reviewed and revised as needed. Social services will follow up with R114, R116, and R26 weekly regarding their meal experience until the next QAPI meeting 1/20/15. The staff who work on the unit where R271 resides were in-serviced regarding dealing with residents with disruptive behaviors at the time of the survey (11/20/14). NA-A was re-educated regarding the importance of sitting with residents while providing assistance with eating. Staff will be retrained on providing for resident dignity, including meal-experience dignity. Facility leadership will complete random dignity and dining experience audits twice per week until the next QAPI meeting 1/20/15. The Director of Nursing will review the completed audits and bring any identified concerns to the QAPI committee for review and further recommendations. The Executive Director or designee will review the weekly	

Accepted 12-23-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcia Findley — TITLE: Executive Director — (X6) DATE: 12/19/14

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.

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 _____	11/21/2014

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 241	Continued From page 1 2-North Observation of the evening meal on 11/17/14, in the facility's 2-North dining room, included the following: · At 5:26 p.m., residents were seated in the dining room, awaiting the evening meal service. R271 repeatedly hit his spoon on the table, resulting in a loud, clanging noise. He also repeatedly yelled out expletives and loudly claimed, "I want my juice. Where is the food? Why did we get down here so fast? ...Why do we got to hurry up, hurry up, no food?" Five various department staff were present in the dining room at time; however, no staff intervened. · At 5:30 p.m., R271 yelled out, "I want water, I want water." He continued to hit his spoon on the table. · At 5:35 p.m., R271 yelled out loudly, "Where is my [expletive] water?" He continued to yell and hit his spoon on the table, with no redirection from the staff present in the dining room. · At 5:36 p.m., R114 (seated behind R271) said to her tablemate, "Do you hear that guy pounding on the table? Even my kids don't do that." · At 5:41 p.m., R271 continued to hit the table with his spoon. An unidentified female resident at a nearby table, yelled, "Who is that pounding on the table?" R271 yelled, "Give me a different spoon." R271 said loudly to a staff member who approached him, "I want steak. I don't want cold rice either." He continued to hit his spoon on the table, in front of the staff, but was not redirected. · At 5:45 p.m., R271 continued to hit his spoon on the table and yell. · At 5:47 p.m., family (F)-B wheeled R271 out of the dining room, down the hall. · At 5:51 p.m., F-B wheeled R271 back into the dining room. R271 yelled out loudly, "Where's our food? I have waited five hours."	F 241	social service follow-up and bring any identified concerns to the QAPI committee for review and further recommendations. See also F282 and F309. The Executive Director is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 241	Continued From page 2 · At 5:52 p.m., R236 (R271's tablemate) asked, "Where's our food?" · At 5:53 p.m., R116 (seated at another table) yelled out, "Shut up." R114 then yelled, "We could have went to McDonalds if we wanted to hear all this noise." · At 5:54 p.m., R271 yelled, "Get out of here. Get out of here. I told you not to feed me. If you feed me, I am going to spit it out." At that time, R114 turned to face R271 and said, "This is a lunch room." R114 then said to staff, "People like that should not be in here." The staff responded by turning R114 back to her table and did not redirect R271. · At 5:56 p.m., nursing assistant (NA)-C approached R271 and asked if he wanted a sandwich. R271 continued to be disruptive, yelling and pounding his spoon on the table. · At 6:00 p.m., NA-C asked F-B if he could take R271 out of dining room. R114 said, "Good, he's gone," as NA-C wheeled R271 out of the dining room. R271's admission Minimum Data Set (MDS) dated 8/27/14, indicated his cognition was intact. The MDS identified R271 displayed verbal behaviors directed toward others (i.e., threatening others, screaming at others and cursing at others) on a daily basis. R114's quarterly MDS dated 5/20/14, indicated severely impaired cognition. R236's quarterly MDS dated 8/27/14, indicated severely impaired cognition. R116's quarterly MDS dated 8/20/14, indicated moderately impaired cognition.	F 241		

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F 241	Continued From page 3 On 11/18/14, at 9:15 a.m. registered nurse (RN) -E stated, "Staff are to try to redirect [R271]. It depends on [R271's] behaviors." RN-E also stated, "We want [R271] to eat out here in the dining room. If [R271] is not redirectable, then staff is to take [R271] to his room." RN-E further stated "Usually [R271's] behaviors increase when his wife is here." RN-E added "[R271] is not very nice to his wife." On 11/18/14, at 9:35 a.m. an interview was conducted with R26, who also ate in the 2-North dining room. R26 stated R271 routinely yelled and swore in the lunch room during meals. R26 added, "It happens at every meal whether his wife is here or not." When asked if these concerns had been relayed to staff, R26 stated, "Staff are present and hear him yell and swear." R26 added, "I don't know why they let it go on." A quarterly MDS dated 8/19/14, indicated R26's cognition was intact. On 11/21/14, at 8:52 a.m. RN-D stated, "Normally [R271] yells out in the dining room." RN-D also stated, "[R271] will yell out for juice or water and if [R271] still yells out, staff will take [R271] to his room and one-to-one [R271]." RN-D further stated, "After [R271] calms down, staff will bring [R271] back to the dining room to eat." RN-D added, "Most of the meals [R271] acts out." Garden Court During the breakfast meal on 11/19/14, at 8:37 a.m. in the Garden Court dining room, the following was observed: · At 8:37 a.m., NA-A stood between R224 and R287, as she assisted both residents to eat their meal. · At 8:49 a.m., NA-A left the table, then returned, still standing as she assisted R224 and	F 241		

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F 241	Continued From page 4 R287 to eat. · At 8:52 a.m., NA-A again left the table, returning with a glass of thickened water. NA-A continued to stand over R224 and R287 as she assisted them to eat their meals. · At 8:56 a.m., NA-A retrieved a glass of water for another resident. Upon her return, she again remained standing while she assisted R224 and R287, until 9:13 a.m., when both residents had completed their meals. R224's quarterly MDS dated 10/22/14, indicated extensive physical assistance from one staff was required for eating. The MDS identified R224's cognition was severely impaired. R287's admission MDS dated 10/22/14, indicated physical supervision/ oversight from one staff was required for eating. The MDS identified R287's cognition was moderately impaired. On 11/19/14, at 9:14 a.m. NA-A confirmed it was expected she remain seated while assisting residents to eat their meals. She stated another NA had taken her seat. She added, she was right-handed and it was easier for her to stand as she assisted both residents with their meal. NA-A acknowledged there were two, extra chairs that were available for use in the dining room, had she chosen to use them. On 11/20/14, at 9:50 a.m. the director of nursing (DON) acknowledged the staff should have remained seated next to residents while assisting them to eat their meals. On 11/20/14, at 10:18 a.m. RN-C, the unit manager, stated she expected the staff to remain seated while assisting with meals. She indicated	F 241		

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F 241	Continued From page 5 all the staff had been educated about sitting and conversing with residents while assisting them with meals. The facility's undated Our Mission form identified the following mission: "To create and manage living environments that emphasize quality of life and enable residents and staff to achieve an optimum level of well-being." The facility's Our Platinum Service Standards form directed staff be considerate and treat residents with dignity and respect.	F 241		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to effectively respond to resident council grievances related to staffing patterns and call light response times, for 2 of 3 resident council members (R40 and R225) interviewed. Findings include: Review of Resident Council meeting minutes from 8/14, to 11/14, identified the following: · According to meeting minutes dated 8/19/14, R40 complained there was not enough	F 244	R40 and R225 have been updated regarding facility's call light action plan. Resident Council has been updated regarding facility's call light action plan. The Resident Council Concern Form has been reviewed and revised. The leadership team will be trained regarding the grievance/concern process, including follow-up requirements. The Executive Director or designee will monitor all Resident Council Minutes and Resident Council Concern Forms to ensure that timely follow-up occurs with the individuals expressing concerns as well as the Council body at its next meeting. The Life Enrichment Director will report resident council concerns to the QAPI committee monthly for review and further recommendations. The Executive Director is responsible for compliance with this requirement.	

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F 244	Continued From page 6 assistance during the past month, with washing up before bedtime. · According to meeting minutes dated 9/16/14, R225 expressed, "Long wait times in the evening, particularly between 9:00 p.m.-10:00 p.m., when it is time to serve breakfast--supper & one day during Labor Day weekend." · Meeting minutes dated 10/21/14, noted, "Long wait times in the evening, particularly between 9:00 p.m. and 10 p.m., when it is time to serve breakfast and supper, and one day during Labor Day weekend." The minutes identified the facility administrator and director of nursing (DON) carried a pager, so they could respond to long call light waits, during business hours. The facility response indicated the administrator and DON would monitor the call light response time daily and follow-up with residents and staff. The meeting minutes also noted,"[R40] expressed a concern about staff telling her that her aid is busy and then shutting the call light off... The staff advised resident to put their call lights back on and report to management." Although a resident concern report was completed for all grievances voiced, thorough follow-up with each resident was not completed, to explain the steps taken by facility management to improve the delivery of care and to act on their grievances in a timely manner. On 11/20/14, at 12:01 p.m. daily call light monitoring documentation was requested. The administrator declined the request, claiming the call light monitoring was a quality assurance document and was not required to be released for review. On 11/21/14, at 8:33 a.m. R40 reported, the lack of assistance from nursing staff was discussed in	F 244	Completion date for certification purposes:	12/30/14

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F 244	Continued From page 7 resident council meetings repeatedly; however, no communication or follow-up was relayed, regarding what was being done to fix the concerns. R40 added, the management was good about listening, but they were not good with following-up on things. She said during the evening, between 9:00 p.m. to 10:00 p.m., "It is really, really bad here, you can't find any help. It is awful." R40 confirmed residents had talked about their concerns in resident council meetings several times, but there was little improvement. R40 stated, "The communication in this place is very bad. You don't know what they are doing to fix the problems." On 11/21/14, at 9:00 a.m. R225 indicated the nursing assistants (NAs) were slow in providing cares. R225 added, she voiced her concerns for the lack of assistance from nursing staff during resident council meetings, but no response was received. R225 stated, in 6/14, the facility's call light system was down, so manual, hand-held bells were used to summon help. R225 indicated although the call system had been fixed, the problem of not receiving help in timely manner persisted, especially during the evening shift. R225 said several residents complained repeatedly of not receiving nursing help in a timely manner, but no follow up had been provided to assure them of a plan to resolve the issue. R225 shared her frustration of being left unattended on her uncomfortable commode for up to 45 minutes, without staff providing her help. She added concerns of staff not filling her portable oxygen tank so that she could ambulate in the hallway and staff turning her call light off, without providing her the assistance she needed before leaving the room. She said, "The communication and follow-up here is very poor."	F 244		

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F 244	Continued From page 8 R225 indicated she did not feel like attending the meetings any longer, because nothing had been done to resolve her concerns shared during the meetings thus far. On 11/21/14, at 11:45 a.m. activity director (staff) -A was interviewed and stated she coordinated monthly resident council meetings. She acknowledged the lack of help from staff had been discussed in the meetings. Staff-A said follow-up was discussed verbally, but they forgot to document their discussions and plans. Staff-A indicated nursing also responded to the resident concerns. On 11/21/14, at 11:58 a.m. DON indicated all resident concerns were investigated immediately and the staff needed to document any follow-up from concerns identified during the resident council meetings. She further indicated the facility was working on the issue of staff not answering call lights timely, or turning them off without taking care of the residents' need.	F 244		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and odor-free environment, for 3 of 6 residents (R26, R39 and R172) reviewed for bathroom odors.	F 253	The bathroom vents in the rooms of R26, R39, and R172 have been cleaned. The bathroom vents in all rooms will be cleaned. The preventive maintenance schedule for vent and duct cleaning has been reviewed and revised. Staff will be in-serviced regarding expectations surrounding the elimination of bathroom odors. Facility leadership will conduct random environmental audits twice per week until the next QAPI meeting 1/20/15.	

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F 253	Continued From page 9 Findings include: On 11/21/14, at 9:04 a.m. R26 stated, "I can smell the poop odor for an hour after [another resident] uses the bathroom ... I have told the staff about it, but they say we cannot have air fresheners in the building." R26 reported the lingering fecal odor really bothered her. R26's quarterly Minimum Data Set (MDS) dated 8/19/14, indicated intact cognition. During observation on 11/21/14, at 9:07 a.m. the exterior grate of a bathroom wall vent, in the shared bathroom of R26, R39 and R172, was covered with black/ brown debris. The interior grate of the vent had a layer of black/ brown debris, approximately 1/8 to 1/4 inch thick, covering the dampers. During the environmental tour on 11/21/14, at 10:01 a.m. maintenance director (MD) stated he was not aware of R26's concern regarding the smell in her bathroom and no staff had reported it to him. At 10:03 a.m. MD verified the outside of the vent was covered with a light coating of dust and the inside dampers of the vent had dust build up. MD then held a tissue in front of the vent to evaluate air flow. When the tissue barely moved, he stated, "I can take care of it, to have the ventilation work better and the dust removed ... The ventilation goes up to mushrooms [mushroom shaped vents] on the roof." MD further stated an outside company was contracted to check on the facility's ventilation system twice annually. The company was at the facility last in 10/14, but was unable to complete their inspection. The company planned to return to the facility soon, to complete their contracted obligations. MD confirmed, depending on which	F 253	The Housekeeping Director will review the completed audits and report any identified concerns to the QAPI committee for review and further recommendations. The Executive Director is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 253	Continued From page 10	F 253		

mushrooms the company checked, this could have been part of the bathroom ventilation problem. MD reported neither maintenance, nor housekeeping, checked dampers for cleanliness on a routine basis. The dampers were checked only if staff reported concerns.

During a follow-up interview on 11/21/14, at 11:26 a.m. R26 stated, "I had brought it up at the resident council meeting in September about the awful odor smelling of poop in my bathroom and how it smells so bad and so long after she [another resident] uses it." R26 also stated, "They told me we cannot use sprays here because of allergies ... and they told me there was nothing they could do about it." Review of Council Minutes dated 10/21/14, confirmed R26 informed staff of the concern. The minutes noted, "A resident [R26] asked how to get rid of odor in the room after someone uses the bathroom. The administrator explained the design and air flow of the building and suggested that resident [R26] make sure bathroom door and room door are open wide to allow air movement. Resident [R26] was also encouraged to ask staff to spray something in room."

The facility's Housekeeping Standard form dated 2/00, directed, "Cleanliness is essential for all areas and departments of the facility for resident comfort, safety and to avoid the spread of infection ... Cleanliness is a must for safe, comfortable and orderly environment of a facility providing housing and care for elderly or frail residents. The activity of cleaning has a direct effect on the comfort, moral and safety of the residents, the staff and the visitors."

The undated Our Mission form decreed, "[Facility

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F 253	Continued From page 11 employees were] responsible for always providing a clean, well maintained and pleasant environment for our residents, guests and employees." A Maintenance Work Order/ Repair Requisition policy dated 11/03, directed all employees to call the maintenance department to report any environment concerns, including repair requests, equipment inspection, etc.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	A new oral health assessment was completed for R17. R17's MDS, assessments, and care plan have been reviewed and updated with oral status information as needed. All other resident medical records will be reviewed by their next quarterly care conference to ensure oral health assessments have been completed. The MDS Coordinator will obtain oral health information from the oral health assessment for the completion of the MDS, CAA, and care plan. MDS Coordinator will notify nurse manager of any dental/oral health concerns. The dental tracking system has been updated and will be reviewed with staff. Nursing staff will be educated on the completion of the oral health assessment and oral section of the MDS. One random oral health assessment audit will be completed by nursing leadership weekly until the next QAPI meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations. See also F279 and F411.	

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	245267	A. BUILDING _____ B. WING _____	11/21/2014

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F 272	Continued From page 12 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide comprehensive assessment of oral/dental status, for 1 of 3 residents (R17) reviewed, with identified oral health concerns. Findings include: R17's Clinical Admission Documentation assessment completed 4/19/14, indicated she had obvious or broken natural teeth; however, the Oral/Dental Status section on the admission Minimum Data Set (MDS) dated 4/19/14, was left blank. R17's care plan dated 4/19/14, and Care Area Assessment (CAA) dated 4/28/14, failed to address R17's dental/oral health status. R17's quarterly MDS dated 10/15/14, revealed diagnoses including Alzheimer's disease, dementia and anxiety. In addition, the MDS indicated R17 had severely impaired cognition and required extensive physical assistance of one	F 272	The Director of nursing is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 272	Continued From page 13 staff with brushing teeth. On 11/17/14, at 5:15 p.m. via a telephone interview, family member (F)-A was asked whether R17 had any oral health concerns. F-A stated, "It's hard to chew, but [R17] has not complained. I know one tooth feel last fall and last month I noticed another missing in the front..." On 11/19/14, at 11:43 a.m. MDS coordinator, registered nurse (RN)-B verified the dental section of R17's comprehensive assessment dated 4/19/14, was not completed and stated she was not sure whether she was the one who had completed the MDS. RN-B stated she expected R17's comprehensive MDS reflect the findings of the Clinical Admission Documentation assessment completed 4/19/14. RN-B indicated licensed practical nurse (LPN)-A had completed R17's MDS and when asked if an RN reviewed the MDS for accuracy after LPN-A had completed it, she indicated "no." On 11/20/14, at 11:11 a.m. R17 was observed pacing back and forth in the unit staff redirecting her and gave her rest periods and water. At 11:12 a.m. R17 was seated on a chair, drinking a cold glass of water in a disposal plastic cup. R17 was noted to be missing a tooth on her right-upper jaw and her front teeth were noted to be yellow. When asked if she had any pain, discomfort or sensitivity, R17 was unable to respond and just patted writer on the arm. On 11/20/14, at 2:17 p.m. LPN-A confirmed she was unable to locate any oral assessments or documentation on her oral health status post completion of the Clinical Admission Documentation assessment completed 4/19/14.	F 272		

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F 272	Continued From page 14 LPN-A verified R17's MDS did not address her dental needs. On 11/20/14, at 4:15 p.m. the director of nursing (DON) stated her expectation was that the staff entered the admission oral health assessment in the MDS and developed a dental care plan for R17, based on the comprehensive MDS assessment. On 11/21/14, at 8:11 a.m. the executive director stated the facility did not have policies or procedures related to assessment, dental or care planning.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	R28 is scheduled to see the dentist 12/19/14. R28's assessments and care plans have been reviewed and updated with oral status information as needed. The oral health assessments and care plans will be reviewed and udpated with oral status information as needed for all other residents by their next quarterly care conference. The dental tracking system has been updated and will be reviewed with staff. Nursing staff will be educated on the completion of the oral health assessment and care plans. One random oral health assessment and care plan audit will be completed by nursing leadership weekly until the next QAPI meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations.	

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F 279	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident's care plan was developed to address dental needs, for 1 of 3 residents (R28) reviewed, with identified oral health concerns. Findings include: R28's undated Face Sheet indicated an admission date of 10/16/14, with diagnoses including end stage renal disease (ESRD) with hemodialysis, diabetes type II, anemia and muscle weakness. R28's Nutritional Assessment dated 10/22/14, indicated an alteration in nutritional status as evidenced by low hemoglobin (blood component that carries oxygen) and low albumin (protein). Review of R28's undated Clinical Notes Report, revealed he was also at high risk for hypoglycemia (low blood sugar) as evidenced by low blood sugar readings. The Analysis of Findings section of the CAA dated 10/29/14, indicated R28 had dental problems noted as, "Ay [sic] have a likely cavity and/or broken natural teeth." The CAA indicated R28 declined use of in-house dental services at the time of assessment. The CAA noted difficulty eating/chewing and diet changes to be monitored and to "proceed to care plan." However, the Care Plan Report dated 10/16/14 lacked evidence of any update to reflect R28's dental problem was monitored and addressed.	F 279	See also F272 and F411. The Director of Nursing is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/1/4

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F 279	Continued From page 16 R28 signed an undated Consent for Treatment and Billing Form for Oral/Dental Status which indicated he wanted a dental examination. On 11/19/14, at 1:18 p.m. R28 stated his last dental visit was three years ago. R28 reported facility staff were aware of this, but did not say anything about a dental appointment. R28 indicated he had "all bad teeth on top," resulting in difficulty when chewing food. He stated,"[I] cannot eat good." On 11/19/14, at 1:53 p.m. registered nurse (RN) -A verified R28 signed a consent wanting to visit with a dentist. RN-A stated LPN-G was responsible for setting up dental appointments. On 11/19/14, at 2:30 p.m. licensed practical nurse (LPN)-G verified there was no dental appointment made for R28 as she was not aware R28 needed one. LPN-G stated she "just called" the dental clinic to set up an appointment for R28 for the next dental visit on 11/21/14. On 11/20/14, 1:57 p.m. the director of nursing (DON) stated she expected nurses to develop the care plan according to the assessment results and to make referrals as needed. On 11/21/14, at 8:11 a.m. the administrator stated the facility did not have policies related to dental care. The facility's Comprehensive Care Plans policy dated 10/06/14, directed: "The care plan/ interdisciplinary assessment team shall develop a comprehensive care plan for each resident to direct care and services. The care plan includes measurable objectives and timetables to meet the	F 279		

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F 279	Continued From page 17 resident's medical, nursing and psychological needs."Care plan procedures included the following: Incorporate identified problem areas; Incorporate risk factors associated with identified problems; Build on identified resident strengths; Reflect treatment goals and objectives in measurable outcomes; Identify the professional services that are responsible for each element of care; Prevent declines in the resident's functional status and/or functional levels, and; Enhance the optimal functioning of the resident by focusing on a rehabilitative program and long term care services which are person centered.	F 279		
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 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to effectively implement care plan interventions for 1 of 1 resident (R271), observed displaying disruptive behaviors during mealtimes, and for grooming for 1 of 3 residents (R193), reviewed for activities of daily living (ADLs). Findings include: R271's written plan of care dated 11/20/14, identified behavior concerns including yelling out, verbal demands and pounding his fists on the bedside table, windowsill or other objects. The	F 282	The care plans and NAR assignment sheets for R271 and R193 have been reviewed and updated as needed. R193's nails have been trimmed and filed. Other residents will have their ADL and behavior care plans updated by their next quarterly care conference. The staff who work on the unit where R271 resides were in-serviced regarding dealing with residents with disruptive behaviors at the time of the survey (11/20/14). Staff will be in-serviced on following care plan interventions/NAR assignment sheets. Facility leadership will complete random nail care and care plan audits twice per week until the next QAPI committee meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations.	

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F 282	Continued From page 18 care plan noted,"[R271] is verbally abusive to staff (yells, screams, swears), resident is verbally and physically abusive to wife."Staff were directed to implement behavior interventions as needed to protect the rights and safety of others. Planned interventions included the following: Approach in a calm manner, divert attention, remove R271 from the situation and take him to another location, spend one-to-one time with him, and remove him from common areas if his behaviors were not redirectable. R271's admission Minimum Data Set (MDS) dated 8/27/14, indicated his cognition was intact. The MDS identified R271 displayed verbal behaviors directed toward others (i.e., threatening others, screaming at others and cursing at others) on a daily basis. The MDS also indicated R271's speech was unclear. He was sometimes understood and was sometimes able to understand others. The MDS identified R271 required extensive assistance from staff for locomotion and eating. Observation of the evening meal on 11/17/14, in the facility 's 2-North dining room, included the following: · At 5:26 p.m., residents were seated in the dining room, awaiting the evening meal service. R271 repeatedly hit his spoon on the table, resulting in a loud, clanging noise. He also repeatedly yelled out expletives and loudly claimed, "I want my juice. Where is the food? Why did we get down here so fast? ...Why do we got to hurry up, hurry up, no food?" Five various department staff were present in the dining room at time; however, no staff intervened. · At 5:30 p.m., R271 yelled out, "I want water, I want water." He continued to hit his spoon on the	F 282	See also F241, F309, and F311. The Director of Nursing is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 282	Continued From page 19 table. · At 5:35 p.m., R271 yelled out loudly, "Where is my [expletive] water?" He continued to yell and hit his spoon on the table, with no redirection from the staff present in the dining room. · At 5:36 p.m., a nearby resident stated, "Do you hear that guy pounding on the table? Even my kids don't do that." · At 5:41 p.m., R271 continued to hit the table with his spoon. An unidentified female resident at a nearby table, yelled,"Who is that pounding on the table?" R271 yelled, "Give me a different spoon." R271 said loudly to a staff member who approached him, "I want steak. I don't want cold rice either." He continued to hit his spoon on the table, in front of the staff, but was not redirected. · At 5:45 p.m., R271 continued to hit his spoon on the table and yell. · At 5:47 p.m., family (F)-B wheeled R271 out of the dining room, down the hall. · At 5:51 p.m., F-B wheeled R271 back into the dining room. R271 yelled out loudly, "Where's our food? I have waited five hours." · At 5:53 p.m., other residents in the area then yelled out, "Shut up ... We could have went to McDonalds if we wanted to hear all this noise." · At 5:54 p.m., R271 yelled, "Get out of here. Get out of here. I told you not to feed me. If you feed me, I am going to spit it out." At that time, a nearby resident turned to face R271 and said,"This is a lunch room. [Then referring to staff said,] People like that should not be in here." The staff responded by turning that resident back to her table and did not redirect R271. · At 5:56 p.m., nursing assistant (NA)-C approached R271 and asked if he wanted a sandwich. R271 continued to be disruptive, yelling and pounding his spoon on the table. · At 6:00 p.m., NA-C asked F-B if he could	F 282		

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F 282	Continued From page 20 take R271 out of dining room. As NA-C wheeled R271 out of the dining room, another resident said, "Good, he's gone." · At 6:24 p.m. as F-B left the facility she stated, "My husband is high strung." On 11/18/14, at 9:15 a.m. registered nurse (RN) -E stated, "Staff are to try to redirect [R271]. It depends on [R271's] behaviors." RN-E also stated, "We want [R271] to eat out here in the dining room. If [R271] is not redirectable, then staff is to take [R271] to his room." RN-E further stated, "Usually [R271's] behaviors increase when his wife is here." RN-E added, "[R271] is not very nice to his wife." On 11/21/14, at 8:52 a.m. RN-D stated, "Normally [R271] yells out in the dining room." RN-D also stated, "[R271] will yell out for juice or water and if [R271] still yells out, staff will take [R271] to his room and one-to-one [R271]."RN-D further stated, "After [R271] calms down, staff will bring [R271] back to the dining room to eat." RN-D added, "Most of the meals [R271] acts out." On 11/21/14, at 8:54 a.m. RN-E stated, "[R271]'s behaviors are yelling, swearing and kicking furniture, just furniture." RN-E indicated staff were to attempt to redirect R271, asking him to stop. She added, "He may stop, or he may not." RN-E stated if R271 did not stop yelling and swearing, staff were to take him back to his room or the television room and talk him down. RN-E also stated staff were just getting to know R271. When asked about the 11/17/14, dining room experience, RN-E stated, "I am surprised staff did not take him [R271] out of the dining room sooner." RN-E added, "We have consulted the physician about [R271]'s behaviors and have	F 282		

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F 282	Continued From page 21 received referral orders." R193's care plan dated 11/24/12, directed, "[R193] will be clean, dressed and well-groomed daily." R193's annual MDS dated 10/27/14, indicated intact cognition, with diagnoses including diabetes mellitus, arthritis, Alzheimer 's disease and general weakness. The MDS identified R193 required extensive assist from one staff for personal hygiene. On 11/17/14, at 4:26 p.m. R193's fingernails on her left hand fingernails were observed as one-half (1/2) inch to three-quarters (3/4) inch in length. The nails were jagged, with dirt visible beneath them. R193's fingernails on her right hand were observed as one-quarter (1/4) to 1/2 inch in length. The nails to her right hand were also jagged, with visible dirt beneath them. R193 stated, "I don't like my long nails. I have never liked long nails." R193 added, "Staff don't trim my nails. It's been months. Staff say they are busy." On 11/19/14, at 7:32 a.m. NA-D confirmed she completed R193's morning cares. NA-D reported the facility nurses trimmed R193 's nails due to her diabetes. NA-D stated R193 's nails were to be trimmed on bath days. NA-D verified R193's weekly bath was scheduled for Tuesday, 11/18/14. On 11/19/14, at 8:37 a.m. R193 was observed while lying in bed. Her fingernails to both hands remained long, jagged and unclean. On 11/20/14, at 9:39 a.m. the director of nursing (DON) stated she expected nursing staff to follow	F 282		

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F 282	Continued From page 22 each resident 's care plan. On 11/21/14, at 12:07 p.m. R193 's fingernails were again observed. They remained long, jagged and unclean. R193 stated, "Staff does not trim my nails. I ask staff to trim my nails, but they say they are too busy." R193 added, "I keep scratching my left side of my face. My nails hurt... The last time staff trimmed my nails they trimmed them too short." The facility 's undated Our Mission form directed, "[Staff were] to create and manage living environments that emphasize quality of life and enable residents and staff to achieve an optimum level of well-being." The facility 's Comprehensive Care Plans policy dated 10/06/14, directed: "POLICY: The care plan/interdisciplinary assessment team shall develop a comprehensive care plan for each resident to direct care and services. The care plan includes measurable objectives and timetables to meet the resident's medical, nursing and psychological needs."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	R271's care plan has been reviewed and updated as needed. Social services will follow up with residents cited as affected by R271's behavior regarding their meal experience weekly until the next QAPI meeting 1/20/15. The staff who work on the unit where R271 resides were in-serviced regarding dealing with residents with disruptive behaviors at the time of the survey (11/20/14). Staff will be re-trained on behaviors, care plans, and providing for	

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F 309	Continued From page 23 by: Based on observation, interview and document review, the facility failed to effectively implement behavior interventions, for 1 of 1 resident (R271) who was randomly observed to display disruptive behaviors during mealtimes. Findings include: R271's written plan of care dated 11/20/14, identified behavior concerns including yelling out, verbal demands and pounding his fists on the bedside table, windowsill or other objects. The care plan noted, "[R271] is verbally abusive to staff (yells, screams, swears), resident is verbally and physically abusive to wife." Behavior interventions were directed to be implemented as needed to protect the rights and safety of others. Planned interventions included the following: Approach in a calm manner, divert attention, remove R271 from the situation and take him to another location, spend one-to-one time with him, and remove him from common areas if his behaviors were not redirectable. R271's admission Minimum Data Set (MDS) dated 8/27/14, indicated his cognition was intact. The MDS identified R271 displayed verbal behaviors directed toward others (i.e., threatening others, screaming at others and cursing at others) on a daily basis. The MDS also indicated R271's speech was unclear. He was sometimes understood and was sometimes able to understand others. The MDS identified R271 required extensive assistance from staff for locomotion and eating. Observation of the evening meal on 11/17/14, in the facility's 2-North dining room, included the	F 309	resident dignity, including meal experience dignity. Facility leadership will complete random care plan and dining experience audits twice per week until the next QAPI meeting 1/20/15. The Director of Nursing will review the completed audits and bring any identified concerns to the QAPI committee for review and further recommendations. See also F241 and F282. The Executive Director is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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	245267	A. BUILDING _____ B. WING _____	11/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 24 following: · At 5:26 p.m., residents were seated in the dining room, awaiting the evening meal service. R271 repeatedly hit his spoon on the table, resulting in a loud, clanging noise. He also repeatedly yelled out expletives and loudly claimed, "I want my juice. Where is the food? Why did we get down here so fast? ...Why do we got to hurry up, hurry up, no food?" Five various department staff were present in the dining room at time; however, no staff intervened. · At 5:30 p.m., R271 yelled out, "I want water, I want water." He continued to hit his spoon on the table. · At 5:35 p.m., R271 yelled out loudly, "Where is my [expletive] water?" He continued to yell and hit his spoon on the table, with no redirection from the staff present in the dining room. · At 5:36 p.m., a nearby resident stated, "Do you hear that guy pounding on the table? Even my kids don't do that." · At 5:41 p.m., R271 continued to hit the table with his spoon. An unidentified female resident at a nearby table, yelled, "Who is that pounding on the table?" R271 yelled, "Give me a different spoon." R271 said loudly to a staff member who approached him, "I want steak. I don't want cold rice either." He continued to hit his spoon on the table, in front of the staff, but was not redirected. · At 5:45 p.m., R271 continued to hit his spoon on the table and yell. · At 5:47 p.m., family (F)-B wheeled R271 out of the dining room, down the hall. · At 5:51 p.m., F-B wheeled R271 back into the dining room. R271 yelled out loudly, "Where's our food? I have waited five hours." · At 5:53 p.m., other residents in the area then yelled out, "Shut up ... We could have went to McDonalds if we wanted to hear all this noise."	F 309		

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F 309	Continued From page 25	F 309		

· At 5:54 p.m., R271 yelled, "Get out of here. Get out of here. I told you not to feed me. If you feed me, I am going to spit it out." At that time, a nearby resident turned to face R271 and said, "This is a lunch room. [Then referring to staff said,] People like that should not be in here." The staff responded by turning that resident back to her table and did not redirect R271.
· At 5:56 p.m., nursing assistant (NA)-C approached R271 and asked if he wanted a sandwich. R271 continued to be disruptive, yelling and pounding his spoon on the table.
· At 6:00 p.m., NA-C asked F-B if he could take R271 out of dining room. As NA-C wheeled R271 out of the dining room, another resident said, "Good, he's gone."
· At 6:24 p.m. as F-B left the facility she stated, "My husband is high strung."

On 11/18/14, at 9:15 a.m. registered nurse (RN) -E stated, "Staff are to try to redirect [R271]. It depends on [R271's] behaviors." RN-E also stated, "We want [R271] to eat out here in the dining room. If [R271] is not redirectable, then staff is to take [R271] to his room." RN-E further stated, "Usually [R271's] behaviors increase when his wife is here." RN-E added, "[R271] is not very nice to his wife."

On 11/21/14, at 8:52 a.m. RN-D stated, "Normally [R271] yells out in the dining room." RN-D also stated, "[R271] will yell out for juice or water and if [R271] still yells out, staff will take [R271] to his room and one-to-one [R271]." RN-D further stated, "After [R271] calms down, staff will bring [R271] back to the dining room to eat." RN-D added, "Most of the meals [R271] acts out."

On 11/21/14, at 8:54 a.m. RN-E stated, "[R271]'s

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F 309	Continued From page 26 behaviors are yelling, swearing and kicking furniture, just furniture." RN-E indicated staff were to attempt to redirect R271, asking him to stop. She added, "He may stop, or he may not." RN-E stated if R271 did not stop yelling and swearing, staff were to take him back to his room or the television room and talk him down. RN-E also stated staff were just getting to know R271. When asked about the 11/17/14, dining room experience, RN-E stated, "I am surprised staff did not take him [R271] out of the dining room sooner." RN-E added, "We have consulted the physician about [R271]'s behaviors and have received referral orders."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS 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 1 of 3 residents (R193) reviewed for activities of daily living (ADLs), necessary assistance with nail care. Findings include: R193's annual Minimum Data Set (MDS) dated 10/27/14, indicated intact cognition, with diagnoses including diabetes mellitus, arthritis, Alzheimer's disease and general weakness. The MDS identified R193 required extensive assist from one staff for personal hygiene.	F 311	R193's care plan and NAR assignment sheet have been reviewed and updated as needed. R193's nails have been trimmed and filed. All other residents will have their nails checked and trimmed as needed. Staff will be in-serviced on nail care and following care plan interventions/NAR assignment sheets. Facility leadership will complete random nail care audits twice per week until the next QAPI meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations. See also F282. The Director of Nursing is responsible for compliance with this requirement.	

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F 311	Continued From page 27 R193's care plan dated 11/24/12, directed, "[R193] will be clean, dressed and well-groomed daily." On 11/17/14, at 4:26 p.m. R193's fingernails on her left hand fingernails were observed as one-half (1/2) inch to three-quarters (3/4) inch in length. The nails were jagged, with dirt visible beneath them. R193's fingernails on her right hand were observed as one-quarter (1/4) to 1/2 inch in length. The nails to her right hand were also jagged, with visible dirt beneath them. R193 stated, "I don't like my long nails. I have never liked long nails." R193 added, "Staff don't trim my nails. It's been months. Staff say they are busy." On 11/19/14, at 7:32 a.m. nursing assistant (NA) -D confirmed she completed R193's morning cares. NA-D reported the facility nurses trimmed R193's nails due to her diabetes. NA-D stated R193's nails were to be trimmed on bath days. NA-D verified R193's weekly bath was scheduled for Tuesday, 11/18/14. On 11/19/14, at 8:37 a.m. R193 was observed while lying in bed. Her fingernails to both hands remained long, jagged and unclean. On 11/20/14, at 9:39 a.m. the director of nursing (DON) stated she expected nursing staff to follow each resident's care plan. On 11/21/14, at 12:07 p.m. R193's fingernails were again observed. They remained long, jagged and unclean. R193 stated, "Staff does not trim my nails. I ask staff to trim my nails, but they say they are too busy." R193 added, "I keep scratching my left side of my face. My nails hurt	F 311	Completion date for certification purposes:	12/30/14

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F 311	Continued From page 28 ... The last time staff trimmed my nails they trimmed them too short." The facility's undated Our Mission form directed, "[Staff were] to create and manage living environments that emphasize quality of life and enable residents and staff to achieve an optimum level of well-being."	F 311		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	The physician orders for R204 were reviewed and Oxycodone orders revised at the time of the survey. R204 was discharged from the facility 11/27/14. The as-needed medication orders for all other residents will be reviewed and updated as appropriate. Medication administration in-services will be held for licensed nurses 12/19/15 and 12/22/15. Nursing staff will receive additional education regarding medication orders. The consultant pharmacist will continue to review resident drug regimens monthly, including specifically looking at as-needed medications and ensuring that parameters are clearly outlined. Nursing leadership will audit new as-needed medication orders each weekday through the next QAPI meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations. See also F428.	

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F 329	Continued From page 29 by: Based on observation, interview and document review, the facility failed to ensure parameters were outlined for the use of oxycodone (a narcotic used to treat severe pain), for 1 of 57 residents (R204) on pain management programs and for the use of lorazepam (a medication used to treat anxiety), for 1 of 8 residents (R204) who received antianxiety medications. Findings include: R204's discharge (return anticipated) Minimum Data Set dated 11/10/14, identified she was cognitively intact, with diagnoses including depression, anxiety and tibia with fibula fracture. R204's Interagency Transfer Form- Physician Orders dated 11/11/14, included the following: - Oxycodone 5 milligrams (mg), one to two tablets (5mg to 10mg) by mouth every four hours, as needed for moderate to severe pain. - Lorazepam 0.5mg, one to two tablets (0.5-1.0 mg) by mouth every six hours, as needed for anxiety or other (sleep, nausea). Review of the Electronic Medication Administration Record (EMAR) for 9/26/14, through 11/20/14, indicated R204 received oxycodone on eighty-two occasions, with various nurses, at different times of the day and varied pain scale responses, with no correlation to the dose administered (no consistency in whether one or two tablets was administered). In addition, R204 received lorazepam twenty-four times, with no clarification to define when one, verses two tablets were to be administered. On 11/20/14, at 7:55 a.m. R204 stated she had	F 329	The Director of Nursing is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 329	Continued From page 30 pain at least daily and used pain medications regularly. R204 reported some of the medications she received were helpful at times, to address her anxiety. On 11/20/14, at 8:45 a.m. registered nurse (RN) -A verified both medications had ranges and acknowledged the pain medication needed to have a pain scale to guide whether one or two tablets of oxycodone were to be administered. RN-A stated it would have been difficult to measure R204's anxiety level to determine whether to administer one or two tablets of lorazepam. On 11/20/14, at 10:03 a.m. RN-C verified R204's orders had no parameters for use. When asked how the facility nurses knew which dose to administer, RN-C stated, "Using nursing judgment the nurses are educated to use the pain scale and for the lorazepam [they would use nursing] judgment also." She further stated she expected the medication orders be clarified by the physician, with the dose of oxycodone correlating with the pain scale. On 11/20/14, at 3:18 p.m. the facility's medical director stated, "I agree with you on that those medications should not have ranges, because they put the nurses in a bind and they are made to make decisions of what to give." He further acknowledged the medications should have been clarified with the primary provider. On 11/20/14, at 4:12 p.m. the director of nursing (DON) stated the medications should have been clarified with the prescribing physician. On 11/21/14, at 8:50 a.m. via telephone, the	F 329		

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F 329	Continued From page 31 consultant pharmacist stated, "[R204's orders] should have been broken down and a pain scale should have been added. They are not correct and need to be specific."	F 329		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to initiate dental referrals when appropriate, for 2 of 3 residents (R17 and R28) reviewed, with oral health concerns. Findings include: R17's Clinical Admission Documentation assessment completed 4/19/14, indicated she had obvious or broken natural teeth. The care plan dated 4/19/14, and Care Area Assessment (CAA) dated 4/28/14, failed to address R17's dental/oral health status.	F 411	The MDS's, assessments, and care plans for R17 and R28 have been reviewed and updated with oral status information as needed. R17's responsible party chooses to decline dental services. R28 is scheduled to see the dentist 12/19/14. The medical records of all other residents will be reviewed by their next quarterly care conference to ensure oral health assessments have been completed. The MDS Coordinator will obtain oral health information from the oral health assessment for the completion of the MDS, CAA, and care plan. MDS Coordinator will notify nurse manager of any dental/oral health concerns. The dental tracking system has been updated and will be reviewed with staff. Nursing staff will be educated on the completion of the oral health assessment and oral section of the MDS. One random oral health assessment audit will be completed by facility leadership weekly until the next QAPI meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations. See also F272 and F279. The Director of Nursing is responsible for	

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F 411	Continued From page 32 R17's quarterly Minimum Data Set (MDS) dated 10/15/14, revealed diagnoses including Alzheimer's disease, dementia and anxiety. In addition, the MDS indicated R17 had severely impaired cognition and required extensive physical assistance of one staff with brushing teeth. On 11/17/14, at 5:15 p.m. via a telephone interview, family member (F)-A was asked whether R17 had any oral health concerns. F-A stated, "It's hard to chew, but [R17] has not complained. I know one tooth feel last fall and last month I noticed another missing in the front..." When interviewed on 11/20/14, at 10:14 a.m. registered nurse (RN)-C, the unit nurse manager, verified R17 did not have a care plan for dental which addressed her broken teeth. RN-C verified the nurse who had completed the oral assessment and MDS should have updated the care plan. On 11/20/14, at 11:11 a.m. R17 was observed pacing back and forth in the unit staff redirecting her and gave her rest periods and water. At 11:12 a.m. R17 was seated on a chair, drinking a cold glass of water in a disposal plastic cup. R17 was noted to be missing a tooth on her right-upper jaw and her front teeth were noted to be yellow. When asked if she had any pain, discomfort or sensitivity, R17 was unable to respond and just patted writer on the arm. On 11/20/14, at 2:17 p.m. licensed practical nurse (LPN)-A confirmed she was unable to locate any oral assessments or documentation on her oral health status post completion of the Clinical	F 411	compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 411	Continued From page 33 Admission Documentation assessment completed 4/19/14. LPN-A verified R17's MDS did not address her dental needs. On 11/20/14, at 4:15 p.m. the director of nursing (DON) stated her expectation was that the staff entered the admission oral health assessment in the MDS and developed a dental care plan for R17, based on the comprehensive MDS assessment. R28's undated Face Sheet indicated an admission date of 10/16/14, with diagnoses including end stage renal disease (ESRD) with hemodialysis, diabetes type II, anemia and muscle weakness. R28's Nutritional Assessment dated 10/22/14, indicated an alteration in nutritional status as evidenced by low hemoglobin (blood component that carries oxygen) and low albumin (protein). Review of R28's undated Clinical Notes Report, revealed he was also at high risk for hypoglycemia (low blood sugar) as evidenced by low blood sugar readings. The Analysis of Findings section of the CAA dated 10/29/14, indicated R28 had dental problems noted as "ay have a likely cavity and/or broken natural teeth." The CAA indicated R28 declined use of in-house dental services at the time of assessment. The CAA noted difficulty eating/chewing and diet changes to be monitored and to "proceed to care plan." However, the Care Plan Report dated 10/16/14 lacked evidence of any update to reflect R28's dental problem was monitored and addressed.	F 411		

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F 411	Continued From page 34 R28 signed an undated Consent for Treatment and Billing Form for Oral/Dental Status which indicated he wanted a dental examination. On 11/19/14, at 1:18 p.m. R28 stated his last dental visit was three years ago. R28 reported facility staff were aware of this, but did not say anything about a dental appointment. R28 indicated he had "all bad teeth on top," resulting in difficulty when chewing food. He stated, "[I] cannot eat good." On 11/19/14, at 1:53 p.m. RN-A verified R28 signed a consent wanting to visit with a dentist. RN-A stated LPN-G was responsible for setting up dental appointments. On 11/19/14, at 2:30 p.m. LPN-G verified there was no dental appointment made for R28 as she was not aware R28 needed one. LPN-G stated she "just called" the dental clinic to set up an appointment for R28 for the next dental visit on 11/21/14. On 11/20/14, 1:57 p.m. the DON stated she expected nurses to develop the care plan according to the assessment results and to make referrals as needed. On 11/21/14, at 8:11 a.m. the administrator stated the facility did not have policies related to dental or care plan processes.	F 411		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425	The medications of R225 have been reviewed to ensure adequate supply. All medication carts have been reviewed for adequate medication supplies. A medication administration in-service will be	

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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 425	Continued From page 35 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available, administered timely and administered as prescribed by the physician, for 1 of 1 resident (R225) with complaints of medications being unavailable at prescribed administration times. Findings include: On 11/18/14, at 12:46 p.m. R225 reported occasions when the facility had run out of her prescribed medications. R225 stated she felt this was unacceptable. She expanded, reporting the following: "One time it was Coumadin [an anticoagulant medication], Advair [a medication used to treat asthma], Tylenol 3 [Tylenol with codeine, a medication used for pain management] which I took daily. Another time it	F 425	held for licensed nurses 12/19/14 and 12/22/14. Nursing leadership will conduct random audits of the medication carts and medication rooms three times per week until the next QAPI meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations. The Director of Nursing is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 425	Continued From page 36 was the pain patch, smoking patch which was out for two weeks and Digoxin [a medication used for the treatment of congestive heart failure]. I sometime have heard the nurses outside my door, but never seen there faces asking [each other] if they had a medication in the cart to borrow for another resident which I believe is not right. When I ask why the medications is not there, [I'm] always told it's not been delivered by the pharmacy and I just end up missing the dose." R225's quarterly Minimum Data Set (MDS) dated 8/8/14, revealed diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), atrial fibrillation (A-fib), depression and insomnia. The MDS indicated R225 had occasional pain, received scheduled pain medications and her cognition was intact. R225's 11/14, Physician Order Sheet revealed the following orders: -Digoxin, 250 micrograms (mcg) by mouth, one time daily for A-fib. -Advair Diskus, 500-50 mcg/dose, one puff blister with inhalation device, two times daily for COPD. -Losartan Potassium, 25 mg by mouth, one time daily for CHF. -Fluticasone Propionate, 50 mcg two sprays suspension to both nostrils, one time daily for nasal congestion. -Lidoderm, 5% (700 mg/patch) one patch applied to lower back, daily at 8:00 p.m. (12 hours on/12 hours off) for pain. -Melatonin, 10 mg by mouth, at bedtime for insomnia. Review of the Electronic Medication	F 425		

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F 425	Continued From page 37 Administration Record (EMAR) for 9/14, to 11/14, revealed the following missed medications for R225: -Digoxin, 8:00 a.m. dose was missed on 10/7/14, and 10/8/14. -Losartan Potassium, 8:00 a.m. dose was missed on 10/2/14. -Melatonin, 8:00 p.m. dose was missed on 10/8/14. -Fluticasone Propionate, 8:00 a.m. dose was missed on 9/2/14, and 9/3/14. -Lidoderm patch, 5% was missed on 9/30/14. On 11/20/14, at 1:57 p.m. licensed practical nurse (LPN)-B stated, "We have policy [that] once we have three to five tabs left, it [the medication] is supposed to be re-ordered, as it takes less than 24 hours to get it." Upon review of the EMAR, LPN-B verified R225 had not received her prescribed medications on multiple days. When asked if the facility had issues with the contracted pharmacy delivering resident medications, LPN-B stated, "Sometimes it happened when the pharmacy say they were out of medications and would send it in 24 to 48 hours, or as soon as they are able to re-fill the medications... The pharmacy would send a copy explaining why the medication was not being refill such as if a medication needs pre-authorization/script or when insurance was not able to cover for the medications." LPN-B acknowledged all residents were supposed to receive their medications as ordered/ prescribed. She also confirmed the contracted pharmacy was required to deliver medications timely, ensuring they were available for administration as prescribed by the physician. On 11/20/14, at 3:39 p.m. the facility's medical director acknowledged a resident missing	F 425		

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F 425	Continued From page 38 medications that were ordered was unacceptable. The medical director confirmed resident medications needed to be available for administration as prescribed by the physician. On 11/20/14, at 4:09 p.m. the director of nursing (DON) stated, "I just came to know [of R225's unavailable medications] now and would have expected the staff to order medications timely. As far as I know, we were getting everything timely and the staff were to call the pharmacy and ask for medications to be refilled if they were running out of any medication, or ask why the medication was not being delivered." During a telephone interview on 11/21/14, at 8:58 a.m. the consultant pharmacist stated, "The facility and the pharmacy need to communicate to ensure residents get their medications as ordered. That is not how it should be. I will have to talk to the pharmacy to see what had happened."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428	R204's physician orders were reviewed and Oxycodone orders revised at the time of the survey. R204 was discharged from the facility 11/27/14. All other residents' as-needed medication orders were reviewed and updated as appropriate. The expectations for monthly resident drug regimen reviews were reviewed with the consultant pharmacist. Medication Administration in-services will be held for licensed nurses 12/19/14 and 12/22/14. Nursing staff will receive additional education regarding medication orders.	

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F 428	Continued From page 39 by: Based on interview and document review, the consultant pharmacist failed to identify parameters were lacking for the use of oxycodone (a narcotic used to treat severe pain), for 1 of 57 residents (R204) on pain management programs and for the use of lorazepam (a medication used to treat anxiety), for 1 of 8 residents (R204) who received antianxiety medications. Findings include: R204's discharge (return anticipated) Minimum Data Set dated 11/10/14, identified she was cognitively intact, with diagnoses including depression, anxiety and tibia with fibula fracture. R204's Interagency Transfer Form- Physician Orders dated 11/11/14, included the following: - Oxycodone 5 milligrams (mg), one to two tablets (5mg to 10mg) by mouth every four hours, as needed for moderate to severe pain. - Lorazepam 0.5mg, one to two tablets (0.5-1.0 mg) by mouth every six hours, as needed for anxiety or other (sleep, nausea). Review of the Electronic Medication Administration Record (EMAR) for 9/26/14, through 11/20/14, indicated R204 received oxycodone on eighty-two occasions, with various nurses, at different times of the day and varied pain scale responses, with no correlation to the dose administered (no consistency in whether one or two tablets was administered). In addition, R204 received lorazepam twenty-four times, with no clarification to define when one, verses two tablets were to be administered.	F 428	The consultant pharmacist will continue to review resident drug regimens monthly including specifically looking at as-needed medications. Nursing leadership will audit new as-needed medication orders each weekday through the next QAPI meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations. See also F329. The Director of Nursing is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 428	Continued From page 40 On 11/20/14, at 7:55 a.m. R204 stated she had pain at least daily and used pain medications regularly. R204 reported some of the medications she received were helpful at times, to address her anxiety. On 11/20/14, at 10:03 a.m. registered nurse (RN) -C verified R204's orders had no parameters for use. When asked how the facility nurses knew which dose to administer, RN-C stated, "Using nursing judgment the nurses are educated to use the pain scale and for the lorazepam [they would use nursing] judgment also." She further stated she expected the medication orders be clarified by the physician, with the dose of oxycodone correlating with the pain scale. On 11/20/14, at 3:18 p.m. the facility's medical director stated, "I agree with you on that those medications should not have ranges, because they put the nurses in a bind and they are made to make decisions of what to give." He further acknowledged the medications should have been clarified with the primary provider. On 11/21/14, at 8:50 a.m. via telephone, the consultant pharmacist stated, "[R204's orders] should have been broken down and a pain scale should have been added. They are not correct and need to be specific." When asked if he had reviewed R204's medications since admission, the consultant pharmacist replied, "Yes I was just there."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	The concerns identified during the survey were immediately corrected at the time of the survey. The expired and undated medications were immediately discarded and replaced with dated medications.	

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F 431	Continued From page 41 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications and supplies were stored in accordance with facility policy and/or manufacturer instruction, including the removal of expired medications/	F 431	All medication carts, medication refrigerators, and medication storage rooms have been reviewed for any expired or undated medications. The Medication Storage policy has been reviewed and revised. Medication Administration in-services will be held for licensed nurses 12/19/14 and 12/22/14. Nursing staff will be re-educated on the Medication Storage policy. Nursing leadership will conduct random audits of medication carts and medication rooms three times per week until the next QAPI meeting 1/20/15. The QAPI committee will review completed audit results and make further recommendations. The Director of Nursing is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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F 431	Continued From page 42 supplies from available use for R273, R162, R135 and R21. This systematic failure to effectively implement medication and supply storage procedures resulted in the potential to affect all 134 residents in the facility. Findings include: 2NW (Two-Northwest) On 11/19/14, observations of the 2NW medication storage areas revealed the following concerns: · At 9:28 a.m., the 2NW medication cart was reviewed with licensed practical nurse (LPN)-C. R273's calcium bottle had no visible expiration date. LPN-C attempted to peel the pharmacy label back to reveal the expiration date printed on the bottle; however, R273's label could not be peeled back. LPN-C stated she did not check medications for expiration dates. · At 9:50 a.m., the second floor medication room was reviewed with LPN-D. Two (2) bottles of influenza vaccine were observed in the refrigerator as opened and undated. LPN-D verified one (1) of the bottles of influenza vaccine was one-half (1/2) full and the other bottle was three fourths (3/4) full. LPN-D then verified 1 bottle of Tubersol (used to screen for tuberculosis), also observed in the refrigerator, was opened and undated. LPN-D stated, "The bottle looks almost full." LPN-D verified the bottle of Tubersol was past the use by date. LPN-D stated, "I would not use a past-dated Tubersol medication for the residents. It would be denatured." LPN-D also verified the following: Eight (8) intravenous (IV) maintenance lines had expired, 1 stock aspirin expired on 10/20/14, 1 canister of Nutrisource expired on 8/14, 2 packages of hearing aide batteries expired on	F 431		

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F 431	Continued From page 43 3/11, and 2 BBL (brand name) culture swabs expired on 7/14. LPN-D then verified the following in the medication room treatment cart: 8 betadine swabs expired on 8/12, four (4) hearing aide batteries expired in 2012, 4 hearing aide batteries expired in 2013, 1 Silvercell dressing expired in 4/14, and ten (10) Prisma dressings expired in 2013. LPN-D stated, "The floor nurses do not check for expiration dates, we are busy." · At 10:54 a.m. LPN-C stated, "We got the influenza vaccine in for the annual vaccinations and administered the residents' vaccinations over a span of two to three weeks." LPN-C also stated when opening a new bottle of influenza vaccine or a bottle of Tubersol, she dated it somewhere on the box and stored it back in the refrigerator. LPN-C further stated if the bottle of influenza vaccine or bottle of Tubersol was already opened she checked for the date it was opened prior to use and if it was before the expiration date, she drew it up for administration. · At 11:09 a.m. LPN-D stated, "When I administered the first influenza vaccination I opened and dated the box." LPN-D also stated the influenza vaccine was only used for the residents. LPN-D further stated the policy was for nurses to check medications and supplies for expiration dates and dispose of medications and supplies if expired. · At 11:12 a.m. registered nurse (RN)-E stated, "The second floor medication room refrigerator is where we store the medications that need to be refrigerated for the residents." · At 11:15 a.m. RN-E stated if a bottle of influenza vaccine is not dated the nurse was to assume the vaccine was expired and dispose of it according to the facility policy for medication destruction. RN-E verified the 2 bottles of influenza vaccine were opened and undated, 1	F 431		

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F 431	Continued From page 44 bottle was one-fourth (1/4) full and the other was 1/2 full. RN-E verified the bottle of Tubersol was opened and undated. RN-E stated the nurses were expected to date bottles of medication when they were opened and check for expiration dates. RN-E also stated the medications and supplies in the medication room were to be checked for expiration dates, every 1 to 2 months by the nurses. · At 11:20 a.m. LPN-E stated she would not use an opened and undated influenza vaccine for the residents as she would not know how long the bottle had been opened. If the vaccine was still good, LPN-E stated she would inspect all dates and would not use the vaccination if expired. 2SE (Two-Southeast) On 11/19/14, at 11:23 a.m. the 2SE medication storage areas were observed and reviewed with LPN-F. The 2SE medication cart included an unopened insulin bottle for R162. LPN-F stated, "It's not opened, so this insulin should be kept in the refrigerator until administering." LPN-F added, "I will have to put it in the refrigerator." The medication cart also included a bottle of docusate plus (stool softener) for R162, with no expiration date identified on the bottle. The medication ammonium lactate for R135 was also identified, with no expiration date. LPN-E verified the medications docusate plus for R162 and ammonium lactate for R135 lacked expiration dates on the containers. 1E (One-East) On 11/19/14, at 1:19 p.m. the 1E medication cart was reviewed with RN-A. One bottle of D3 (vitamin D) 2000 IU's (international units) was observed in the cart, with no expiration date on the bottle. RN-A stated she checked the	F 431		

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F 431	Continued From page 45 medication room for expired medications the week prior. RN-A stated, "The floating supervisor is the one who does that." SAU (Sub-Acute Unit) On 11/20/14, at 8:56 a.m. medication storage areas were reviewed with RN-F. R21's bottle of melatonin had an expiration date that was partially covered by the pharmacy label. RN-F verified R21's pharmacy label covered the expiration date, making it unidentifiable. RN-F stated, "Policy is to date bottles of medication upon opening, some nurses don't, not consistent." At 9:11 a.m., the refrigerator included 1 opened bottle of influenza vaccine, dated as opened on 10/10/14. The bottle was 3/4 full. RN-F verified the bottle of vaccine was past the date of usage. RN-F stated, "I am sure this vaccine has been used, I would toss it away." RN-F also stated, "The pharmacy people come in and do rounds and check for expiration dates, but ultimately it is up to us nurses to check the expiration dates before administrating the medication." Ten influenza testing kits were observed, all of which had expired on 8/14. Sixteen culture swabs were observed, all of which had expired on 7/14. RN-F verified the expired supplies and indicated they needed to be discarded. GC (Garden Court) On 11/21/14, at 9:07 a.m. the GC medication room was reviewed with RN-G. · BBL culture swabs were observed and verified by RN-G to be expired. RN-G stated, "Lab will not take these since we switched over to other blue ones for nasal swabs." RN-G reported the facility's nurse managers order supplies. RN-G added the floor nurses were to check the	F 431		

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F 431	Continued From page 46 supplies on a routine basis. Observations in the GC medication room also included the following expired supplies: Salter labs (brand name) latex free nasal cannula tubing and nebulizer mask, 2 Rusch/ MMG (brand name) urinary catheterization system with red rubber catheter tubing, and one Macrobore (brand name) IV extension set with clave Hospira (brand name) expired on 10/04. RN-G verified these observations and stated, "I guess I didn't think to check these supplies."The GC refrigerator had 1 opened bottle of influenza vaccine dated 10/15/14. RN-G verified the bottle was past the date of usage. RN-G stated, "I would not use this bottle of influenza vaccine, I would open a new bottle and date it because opened influenza vaccine is only to be used for thirty days." The refrigerator temperature was observed and verified by RN-G as 47 degrees Fahrenheit (F). RN-G stated, "The night nurses check the refrigerator temperature, day nurses don't ever check the refrigerator temperature." RN-G stated she did not know what temperature range the medication refrigerator temperature was expected to remain within, but stated she would find out. · At 9:47 a.m., RN-G stated she had asked the facility director of nursing (DON) and the expected temperature range was 36 to 46 degrees F. RN-G also stated the DON said the facility had not used the supplies for a while and they came from lab. RN-G further stated when a refrigerator temperature was out of range, she called maintenance and the pharmacy to see if the medications were still okay to administer to the residents. On 11/20/14, at 1:54 p.m. the DON stated the nurses were expected to check expiration dates	F 431		

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F 431	Continued From page 47 for medications and supplies in the carts and medication rooms. The DON added nurses were expected to date resident medications upon opening. The facility's Storage of Medication policy dated 09/10, directed, "Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration."The policy indicated medications requiring refrigeration or temperatures control were to be kept in a refrigerator with a thermometer to allow for temperature monitoring. The policy noted insulin products were to be stored in a refrigerator until opened. The facility's Medications with Special Expiration Date Requirements policy dated 12/12, directed, "The date of opening should be noted on the container/vial. Tubersol expiration date 30 days after opening (store in refrigerator)." The undated PharMerica manufacturer instructions directed, "Influenza vaccine expires 30 days after open, Tubersol injectable expires 30 days after open." The Centers for Disease Control (CDC) 2014-2015, guidelines for Packing, Shipping, Handling & Storing Influenza Vaccine updated 9/19/14, directed,"Vaccines exposed to temperatures outside the recommended ranges, can have decreased potency and protection... Vaccines are fragile. They must be maintained at the temperatures recommended by vaccine manufacturers..." The guidelines instructed all refrigerated influenza vaccinations were to be stored between 35 to 46 degrees F, with a	F 431		

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 _____	11/21/2014

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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F 431	Continued From page 48 desired average temperature of 40 degrees F.	F 431		

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

F5267023

PRINTED: 12/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2014**

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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. 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 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 (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	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. 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. POC ok 12-23-14	

DC: 12-31-14

EXIT: 11-21-14

RECEIVED
DEC 22 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

Executive Director | 12/19/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2014**

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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. 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 132 at the time of the survey. A K-067 has been written in past surveys. upon further detailed investigation it has been found	K 000		

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K 000	Continued From page 2 that The supply and return for the 1967 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This deficient practice could affect all residents, guests and staff within the smoke compartments Findings include: On facility tour between 09:00 AM and 01:00 PM on 11/19/2014, it was observed that the 1st floor Laundry Room had penetrations in the corridor wall around conduit and pipes. This deficiency was verified by the Maintenance	K 029	The penetrations in the corridor wall of the laundry room have been eliminated. The Maintenance Director is responsible for compliance with this requirement. Completion date for certification purposes:	12/30/14

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K 029	Continued From page 3 Director (BS),	K 029		