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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: G1TQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00997

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245063**

2.STATE VENDOR OR MEDICAID NO.
(L2) **491343400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/05/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 12/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 12/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/27/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245063
December 19, 2016

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

Dear Mr. Barker:

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

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

Effective the above facility is certified for or recommended for:

84 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 19, 2016

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

RE: Project Number S5063027

Dear Mr. Barker:

On October 31, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 20, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 9, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 20, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 20, 2016, effective November 30, 2016 and therefore remedies outlined in our letter to you dated October 31, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245063 Y1	A. Building B. Wing Y2	12/5/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0312	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	11/30/2016	LSC	11/30/2016	LSC	11/30/2016
ID Prefix F0315	Correction	ID Prefix F0334	Correction	ID Prefix F0371	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.35(i)	Completed
LSC	11/30/2016	LSC	11/30/2016	LSC	11/30/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 12/19/2016	SIGNATURE OF SURVEYOR 16022	DATE 12/05/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
10/20/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245063	A. Building 01 - MAIN BUILDING 01 B. Wing	11/9/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 11/01/2016	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 11/01/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 11/01/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 12/19/2016	SIGNATURE OF SURVEYOR 37008	DATE 11/09/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: G1TQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00997

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245063**

2.STATE VENDOR OR MEDICAID NO.
(L2) **491343400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/20/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Cynthia Wentkiewicz, HFE NE II — 11/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/23/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 31, 2016

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

RE: Project Number S5063027

Dear Mr. Barker:

On October 20, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 20, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5063014 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 29, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 20, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 20, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 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
	245063	A. BUILDING _____ B. WING _____	10/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5063014 was completed and found not to be substantiated.	F 000		
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	F 279		11/18/16

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

Electronically Signed | 11/10/2016

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

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	245063	A. BUILDING _____ B. WING _____	10/20/2016

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F 279	Continued From page 1 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R13) reviewed for urinary incontinence. Findings include: R13's admission Minimum Data Set (MDS), dated 6/12/16, revealed R13 was occasionally incontinent (less than 7 documented episodes of incontinence). R13's quarterly MDS, dated 9/10/16, revealed R13 was frequently incontinent (more than 7 documented episodes of incontinence, but at least one episode of continent voiding). Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence care plan initiated until 10/19/16. Review of R13's NAR (nursing assistant) daily assignment sheet, dated October 19, 2016 revealed the following: "Incontinence: No; Incontinent Products:[blank]; Able to communicate the need to void-Uses call light." R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistant, (NA)-C was observed assisting R13 to pull incontinence brief and pants down and sit on the toilet. R13 noted her incontinence brief was wet.	F 279	St. Anthony Park Home will develop a care plan for residents regarding urinary incontinence. Resident 13's care plan was updated and the NAR care sheets have been updated with the appropriate information. Each resident's care plan will be reviewed to ensure the proper urinary incontinence plan is in place. NAR care sheets will reflect what is in the care plan.	

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F 279	Continued From page 2 NA-C then assisted R13 with providing perineal care. After assisting R13 with toileting, NA-C reported R13's incontinence brief was wet today and she assisted with providing perineal care. NA-C reported R13 was able to inform staff when she needed to use the toilet. On 10/19/16, at 1:32 p.m. registered nurses (RN)-B and (RN)-C confirmed there was no comprehensive care plan for urinary incontinence for R13. RN-C and RN-B reviewed the NAR (nursing assistant) daily assignment sheet and explained it was a care guide for the nursing assistants, not a comprehensive care plan. RN-B and RN-C confirmed the daily assignment sheet indicated R13 did not experience incontinence, did not wear an incontinence brief and was able to communicate the need to void. When asked if the daily assignment sheet was accurate, RN-C shrugged her shoulders. RN-B and RN-C reported the daily assignment sheets were frequently changed and past copies were not retained. The Bowel and Bladder Assessment Policy, undated, directed staff: "Upon identifying resident's program, an appropriate plan of care will be implemented. Resident's individual toileting program will be on the nursing assistant's care sheets and resident care plan."	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.	F 282		11/18/16

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F 282	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan related to activities of daily living (ADLs) for 1 of 3 residents (R54) reviewed for ADLs. Findings include: On 10/19/16, at 9:48 a.m. nursing assistant (NA)-A was noted to wheel R54 from the dining room to her bedroom, near her bed. NA-A put transfer belt around R54's waist and said "can you give me a hug?, can you hold onto me?", then assisted R54 to a standing position and pivoted her to her bed and to lay down. NA-A then assisted R54 to roll onto her side to pull her pants down and remove her incontinence brief. NA-A then cleaned R54's bottom with toilet paper. No other staff was present to assist R54. R54 moaned quietly while being transferred, turned and assisted with brief changes and peri-care. On 10/19/16, at 10:56 a.m. NA-A reported R54 needed assistance from 1-2 staff for bed mobility, transfers and toileting, depending on how she was doing. R54's NAR (nursing assistant) daily assignments, dated 10/19/16, directed staff: "Transferring: 2 Assist" and "Bed Mobility: 2 Assist." R54's care plan, last revised 10/17/16, directed staff: "The resident has an ADL self-care performance deficit r/t (related to) terminal Alzheimer's disease." and "Bed Mobility: The resident requires physical assistance by 2 staff to turn, reposition and boost up in bed." and "Toilet	F 282	St. Anthony Park Home will ensure that care plans are accurate regarding transferring and that nursing assistants follow the care plan. Resident 54's care plan has been corrected and the NAR care sheet reflects that accurate information regarding transfers. Each resident's care plan will be reviewed to ensure the transfer and bed mobility information is accurate.	

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F 282	Continued From page 4 Use: The resident requires physical assistance by 2 staff for dignity toileting." and "Transfer: The resident requires physical assistance of 1-2 staff with pivot transfers." The care plan, last revised 10/20/16, further directed staff "Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface." On 10/19/2016, at 1:30 p.m., RN-C confirmed R54 required assistance of 1-2 staff for transfers and assistance of 2 staff for toileting and bed mobility per R54's care plan. RN-C reported nursing assistants should follow directions on the NAR daily assignment sheet.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services related to activities of daily living (ADLs) for 1 of 3 residents (R54) reviewed for ADLs. Findings include: R54's most recent Minimum Data Set (MDS), dated 8/28/16, revealed R54 had both long and short term memory problems as well as no recall	F 312	Nursing staff will provide the necessary services, as directed by the care plan, regarding transferring and bed mobility. Resident 54's care plan is accurate and the NAR care sheet reflects the accurate care plan information regarding transferring and bed mobility. Each residents care plan will be reviewed and updated if need be to reflect accurate assistance needed for bed mobility and transferring.	11/23/16

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F 312	Continued From page 5 ability and severely impaired decision making. The MDS further indicated R54 required extensive assistance from two staff for bed mobility, transfers and toileting. On 10/19/16, at 9:48 a.m. nursing assistant (NA)-A was noted to wheel R54 from the dining room to her bedroom, near her bed. NA-A put transfer belt around R54's waist and said "can you give me a hug?, can you hold onto me?", then assisted R54 to a standing position and pivoted her to her bed and to lay down. NA-A then assisted R54 to roll onto her side to pull her pants down and remove her incontinence brief. NA-A then cleaned R54's bottom with toilet paper. No other staff was present to assist R54. R54 moaned quietly while being transferred, turned and assisted with brief changes and peri-care. On 10/19/16, at 10:56 a.m. NA-A reported R54 needed assistance from 1-2 staff for bed mobility, transfers and toileting, depending on how she was doing. R54's care area assessment, dated 9/2/16, revealed "Resident is no longer ambulatory and requires staff assist with all ADL's (activities of daily living). Receives physical staff assist with all bed mobility and transfers." and "Requires extensive to total staff assistance for all toileting tasks including peri-care, brief change, and clothing adjustment." R54's NAR [nursing assistant] daily assignments, dated 10/19/16, directed staff: "Transferring: 2 Assist" and "Bed Mobility: 2 Assist." R54's care plan, last revised 10/17/16, directed staff: "The resident has an ADL self-care	F 312	Nursing assistants will be in serviced on the requirement to provide care as directed by the care plan. ADL's involving transfers will be monitored intermittently on a daily basis. The DON, ADON and QA nurses will ensure the above mentioned monitoring is completed.	

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F 312	Continued From page 6 performance deficit r/t (related to) terminal Alzheimer's disease." and "Bed Mobility: The resident requires physical assistance by 2 staff to turn, reposition and boost up in bed." and "Toilet Use: The resident requires physical assistance by 2 staff for dignity toileting." and "Transfer: The resident requires physical assistance of 1-2 staff with pivot transfers." The care plan, last revised 10/20/16, further directed staff "Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface." On 10/19/2016 at 1:30 p.m., RN-C confirmed R54 required assistance of 1-2 staff for transfers and assistance of 2 staff for toileting and bed mobility. RN-C reported nursing assistants should follow directions on the NAR daily assignment sheet. If a nursing assistant noticed residents needed a different level of care than on the NAR daily assignment sheet, the nursing assistant should inform the nurse on the unit. The nurse should then re-evaluate and consult with occupational or physical therapy as needed.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		11/23/16

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F 315	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident reviewed for urinary incontinence (R13) was provided with the services necessary to achieve the highest practicable level of bladder function. Findings include: R13's admission Minimum Data Set (MDS), dated 6/12/16, revealed R13 was occasionally incontinent (less than 7 documented episodes of incontinence) and required limited assistance for toilet use. R13's quarterly MDS, dated 9/10/16, revealed R13 was frequently incontinent (more than 7 documented episodes of incontinence, but at least one episode of continent voiding) and required extensive assistance for toilet use. R13's urinary care area assessment, dated 6/15/16, revealed "Resident had 2 documented episodes of incontinence during observation period and was highly involved in toileting task but did receive physical assistance for management of clothing, transfers to toilet, and peri-care with incontinence episodes. Resident wears a pull up at all times." Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence care plan initiated until 10/19/16. Review of R13's NAR (nursing assistant) daily assignment sheet, dated October 19, 2016 revealed the following: "Incontinence: No; Incontinent Products:[blank]; Able to communicate the need to void-Uses call light."	F 315	St. Anthony Park Home has implemented the appropriate care plan regarding urinary incontinence for resident 13. The care plans for other residents will be reviewed and updated, if necessary, with the correct urinary incontinence plan. The NAR sheets will accurately reflect the care plan. Nursing assistants will be in serviced on the requirement to provide care as directed by the care plan.	

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F 315	Continued From page 8	F 315		

R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence.

On 10/19/16, at 9:33 a.m. nursing assistant, (NA)-C was observed assisting R13 to pull incontinence brief and pants down and sit on the toilet. R13 noted her incontinence brief was wet. NA-C then assisted R13 with providing perineal care. After assisting R13 with toileting, NA-C reported R13's incontinence brief was wet today and she assisted with providing perineal care. NA-C reported R13 was able to inform staff when she needed to use the toilet.

On 10/19/16, at 1:32 p.m. registered nurses (RN)-B and (RN)-C confirmed R13 went from occasionally incontinent on the admission MDS, dated 6/12/16, and frequently incontinent for the MDS, dated 9/10/16. RN-B and RN-C were unable to articulate the reason R13 declined in bladder function. RN-B and RN-C reported there was no comprehensive care plan for urinary incontinence for R13. RN-C and RN-B reviewed the NAR (nursing assistant) daily assignment sheet and explained it was a care guide for the nursing assistants, not a comprehensive care plan. RN-B and RN-C confirmed the daily assignment sheet indicated R13 did not experience incontinence, did not wear an incontinence brief and was able to communicate the need to void. When asked if the daily assignment sheet was accurate, RN-C shrugged her shoulders. RN-B and RN-C reported the daily assignment sheets were frequently changed and past copies were not retained.

The Bowel and Bladder Assessment Policy, undated, directed staff: "Upon identifying

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F 315	Continued From page 9 resident's program, an appropriate plan of care will be implemented. Resident's individual toileting program will be on the nursing assistant's care sheets and resident care plan."	F 315		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's	F 334		11/30/16

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F 334	Continued From page 10 legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pneumococcal vaccines were offered to 5 of 5 residents (R20, R40, R36, R43, R6) whose immunization records were reviewed. In addition, the facility failed to develop	F 334	St. Anthony Park Home has developed accurate guidelines for Pneumococcal Conjugate Vaccine (PCV)-13 as developed by the CDC. Resident R20, R40, R36, R43 and R6	

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F 334	Continued From page 11 accurate guidelines for Pneumococcal Conjugate Vaccine (PCV)-13 as recommended by the Centers for Disease Control (CDC). Finding include: R20 admitted to the facility on 10/27/12. Immunization records revealed the resident had received pneumococcal polysaccharide vaccination (PPV-23) on 5/4/07. There was no indication the PCV-13 and second dose of PPSV 23 had been offered to R20. R40 admitted to the facility on 5/8/14. Immunization records revealed resident received a PPSV-23 on 01/20/04, however, the medical record lacked evidence R40 was offered the second dose of PPSV 23 as well as PCV-13. R36 admitted to the facility on 3/20/08. Immunization records revealed R36 received a PPSV-23 on 10/25/05; however, the medical record lacked evidence R36 was offered the second dose of PPSV 23 and PCV-13. R43 was 97 years old, and was admitted to the facility on 9/21/11. Immunization records indicated R43 received a PPSV-23 on 7/4/08; however, the medical record lacked evidence R43was offered the second dose of PPSV 23 and PCV-13. R6 admitted to the facility on 7/15/15. Immunization records revealed R6 had received pneumococcal polysaccharide vaccination PPV-23 on 10/18/06. There was no indication PCV-13 and the second dose of PPSV 23 had been offered to R6. During interview with assistant director of nursing	F 334	have been offered the proper vaccine within the proper guidelines. All other residents of the facility will be reviewed and, if necessary, given the vaccine as per the proper guidelines. A spreadsheet has been developed to monitor each resident, the vaccines that have been received, when the next vaccine is due and which vaccine is due.	

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F 334	Continued From page 12 (ADON) on 10/20/16, at 9:29 a.m. ADON stated "I know you are asking me about the Pneumovax but we did not update our system yet." During interview with the Director of nursing (DON) on 10/20/16, at 12:07 p.m. The DON stated "we are work in progress,we do not have an actual policy approved by the facility in place, but at this point we are going with the physician directive and recommendation, it is something we are looking into, ADON got the training last week and she put this policy in place but needs to be reviewed. We are planning to incorporate all the pneumococcal vaccination as recommended." Policy: Undated policy titled, "Policy for Pneumococcal immunization" indicated "Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized.... the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. Vaccine received resident will receive either PCV 13 (Prevnar 13) or PPSV 23 (Pneumovax 23).... Resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal."	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		11/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING _____ B. WING _____	10/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen and ice machines were maintained in a clean and sanitary manner. This had the potential to affect residents who were served food and or ice related, to the deficiencies noted below. Findings include: On 10/17/16, at 12:30 p.m. fruit flies were observed to be flying around near sandwiches on the counter. There was a heavy buildup of crumbs and dust on the dishwasher. A disposable pan was noted to be washed and put on the drying counter. The clean dishes drying counter, above the clean dishes from the dishwasher, was noted to have blue plastic peeling off the metal racks. On 10/20/16, at 10:10 a.m. the dietary supervisor (DS) confirmed a heavy buildup of orange and brown crumbs and dust on top of the dishwasher. DS sprayed the top of the dishwasher and wiped with a rag, which caused dust and crumbs to fall on the clean dish side. DS was not sure what the buildup of crumbs and dust were from. DS confirmed the disposable pans were washed and reused for serving hot food. DS confirmed the drying racks had blue plastic peeling from the metal. The first floor ice machine was noted to have orange buildup on the upper side of the machine. It was full of ice. On the 2nd floor, the	F 371	St. Anthony Park Home does, and will, manage food under sanitary conditions. Pest services have made an additional service stop for the kitchen and will continue to make additional stops as necessary. Although the alleged “fruit flies” were not fruit flies, according to our pest service, we have purchased a specific container for bananas and other fruits that come in boxes. The top of the dishwasher has been cleaned and is now on a schedule for daily cleaning. The drying racks have been replaced and one time use aluminum pans will be discarded after one use. Dietary staff have been in serviced on the schedule for cleaning the top of the dishwasher and the one time use of aluminum foil pans. The manufacturer’s recommendations for cleaning the 2nd floor ice machine have been initiated. The 1st floor ice machine has been cleaned. The dietary manager will monitor the cleanliness of the dishwasher and the kitchen for any pests on a daily basis. The Maintenance director will perform the servicing and cleaning of the 1st and 2nd floor ice machines as per the manufactures recommendations.	

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	245063	A. BUILDING _____ B. WING _____	10/20/2016

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(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 371	Continued From page 14 ice and water machines had white, yellow, orange and red in the ice and water chutes and on the tray under the chutes. DS reported she did not monitor the cleaning and maintenance of the ice and water machines. The housekeeping manager reported housekeepers just wipe the outside of the ice and water machines. The maintenance manager (MM) reported he cleaned the inside of the 1st floor ice bin about every 6 months but did not have a cleaning procedure for the 2nd floor ice and water machine. MM confirmed buildup of white, yellow, orange and red substance in the ice and water chutes and tray below. MM was not able to provide manufacturer recommendations for cleaning the 2nd floor ice and water machine. The Ice Machine and Refrigerators Policy, undated, directed staff "1. Wash outside surfaces daily. 2. Rinse and dry." An email from the food and kitchen equipment supplier, printed 10/20/16, noted "those aluminum pans are NOT meant to be reused."	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING _____ B. WING _____	10/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing during cares was completed for 2 of 4 (R54, R59) residents reviewed for personal cares. Findings include: On 10/19/16, at 9:48 a.m. nursing assistant (NA)-B removed R54's soiled incontinence brief and applied a new brief with gloved hands. NA-B noted R54 was continuing to produce a bowel	F 441	St. Anthony Park Home will ensure proper handwashing techniques and glove use will be used during cares. All nursing assistants will receive training on our glove use policy, as well as our handwashing policy. A handwashing return demonstration will be required of all nursing assistants. Glove use and handwashing will be monitored intermittently on a daily basis. The DON, ADON and QA nurses will ensure the above mentioned monitoring is	

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	245063	A. BUILDING _____ B. WING _____	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 441	Continued From page 16 movement so she would come back and change R54 again shortly. NA-B then gathered the bag of soiled incontinence brief and toilet paper, went into the bathroom and came right back out within 10 seconds to R54. NA-B was not wearing gloves. NA-B then put the blanket on R54, moved her call light and R54's hands near the call light. NA-B then opened the door and went into the nearby room to wash hands. NA-B confirmed she removed her gloves but did not wash her hands until after she left the room. On 10/18/16, at 9:42 a.m. NA-A and NA-D were observed assisting R59 from his wheelchair into a mechanical standing lift. NA-A assisted R59 with sitting upright while NA-D placed leg straps up. NA-A and NA-D then assisted R59 with standing up with use of the mechanical standing lift and move him into the bathroom, assisted him with removing pants and incontinence brief and pulling pants down and helped him sit on the toilet. NA-D washed her hands for five seconds, then wiped them on her pants to dry them. NA-D then left the room. NA-A remained in the room to supervise R59. R59 had a bowel movement in the toilet. At 10:12 a.m. NA-D returned to assist R59 stand near the toilet as NA-A wiped R59's perineal area, applied a brief and pulled his pants back up. NA-A removed her gloves but did not wash or sanitize hands. NA-D and NA-A moved R59 from the toilet to the bed and to sit and rest in his bed. NA-A and NA-D then removed R59's shoes. NA-D straightened the blankets on R59's bed, placed a wedge under R59's legs and moved a floor mat into place near R59's bed. NA-D then removed her gloves and washed her hands for five seconds, dried with paper towel and left the room. NA-A called for the nurse and then exited the room with garbage and washed her hands in	F 441	completed.	

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	245063	A. BUILDING _____ B. WING _____	10/20/2016

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ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

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F 441	Continued From page 17 the staff bathroom. On 10/19/16, at 10:47 a.m. the assistant director of nursing (RN)-E reported she would expect nursing assistants to wash or sanitize hands according to how they were trained per the policy and procedure and hand sanitizer was available to use as appropriate. The Handwashing policy, updated 3/19/12, directed staff "Wet hands with running water. 2. Apply soap and thoroughly disperse over hands. 3. Vigorously rub hands together for 10-15 seconds generating friction on all surfaces including under fingernails. 4. Rinse thoroughly. 5. Pat dry thoroughly with paper towels. 6. Turn faucet off using a paper towel to protect hands from dirty faucet. 7. Dispose of paper towel in waste basket. 8. Hands are to be washed before and after providing personal cares for a resident, between residents, before leaving a dirty area and entering a clean area, after removing gloves, etc. Hand hygiene may also be performed with the use of antiseptic hand rub as follows: 1. Make sure all organic matter is removed from hands (i.e. visible dirt) 2. Apply a dime sized amount of hand sanitizer to the palm of one hand or use a waterless hand sanitizer wipe. 3. Rub hands together covering all surfaces of hands and fingers. Rub until hand sanitizer is absorbed. 4. Wash hands with soap and water after every 10-15 uses of hand sanitizer."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING **02 - ANOKA CARE & REHAB CENTER** B. WING _____	**10/19/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	**3000 4TH AVENUE ANOKA, MN 55303**

(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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 19, 2016. At the time of this survey Anoka Rehabilitation & Living Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. Anoka Care-Rehabilitation Center was constructed in 2012 and opened in 2013. It is a two story building with a basement. The construction type is determined to be Type II (111). The building is separated from the rest of the complex by 2 hour fire rated construction. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 120 beds and 109 were occupied at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

Electronically Signed | 11/12/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on October 19, 2016. At the time of this survey, St Anthony Park Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/01/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The St Anthony Park Home was constructed at three different times. The original building was built in the 1900s, is 3 stories, with a basement and was determined to be of a Type II (111) construction with a wood frame roof system that meets the exception to "The Life Safety Code" NFPA 101 (2000 edition) Section 16.1.6.2. In 1960 an addition was constructed to the west of original building, which was 1-story, with a basement, and was determined to be Type II (111) construction. In 1999 a 2nd and 3rd floor were constructed over the 1960 addition that are separated with a 2 hour fire barrier from the 1900 original building and are Type II(111) construction. The building is divided into 11 smoke zones (3 each level except the basement) by at least 1 hour fire barriers. An automatic sprinkler system is installed throughout the building. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces and in all the sleeping rooms of the 1999 additions. Additional automatic fire detection is provided in	K 000		

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	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2016**

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ST ANTHONY PARK HOME	**2237 COMMONWEALTH AVENUE** **SAINT PAUL, MN 55108**

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K 000	Continued From page 2 all rooms required by the Minnesota State Fire Code. The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 81 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors	K 018	The door to room 303 and the 2nd floor west elevator doors have been repaired. The maintenance director will monitor doors to ensure they latch and unlatch properly.	11/1/16

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	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2016**

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

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K 018	Continued From page 3 in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 On facility tour between 09:00 AM and 01:00 PM on 10/19/16, based on observation and interview revealed that the findings iclude: 1. Resident room 303 has a door that does not latch closed when tested. 2. The 2nd floor west elevator door does not unlatch when tested. This deficient practice could affect the safety of all the residents, staff and vistors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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	K 029		11/1/16

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K 029	Continued From page 4 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: One hour fire rated construction (with o 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 On facility tour between 09:00 AM and 01:00 PM on 10/19/16, based on observation and interview revealed that the findings include: 1. 2nd floor east utility room has a door for cabinet suppling cable TV that is not a rated access door. This deficient practice could affect the safety of all the residents staff and vistors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 029	A magnetic latch was placed on the door in the 2nd floor east utility room in order to achieve compliance.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	K 147	An outlet cover was placed on the outlet above the 2nd floor stairwell door and one of the refrigerators was plugged directly	11/1/16

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	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2016**

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ST ANTHONY PARK HOME	**2237 COMMONWEALTH AVENUE** **SAINT PAUL, MN 55108**

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K 147	Continued From page 5 On facility tour between 09:00 AM and 01:00 PM on 10/19/16, based on observation and interview revealed that the findings include. 1. 2nd floor dining area stairwell has a outlet above door with no cover plate. 2. 1st floor nurse storage room has two refrigerator's plug into a power tap. This deficient practice could affect the safety of all residents, staff and vistors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 147	into an outlet with the other being on a power strip. The maintenance director will monitor the facility for proper use of power strips.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
October 31, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5063027

Dear Mr. Barker:

The above facility was surveyed on October 17, 2016 through October 20, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5063014 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
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
	00997	A. BUILDING: _____ B. WING _____	10/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 17, 18, 19 and 20th, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. An investigation of complaint H5063014 was completed and found not to be substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R13) reviewed for urinary incontinence. Findings include: R13's admission Minimum Data Set (MDS), dated 6/12/16, revealed R13 was occasionally incontinent (less than 7 documented episodes of incontinence). R13's quarterly MDS, dated 9/10/16, revealed R13 was frequently incontinent (more than 7 documented episodes of incontinence, but at least one episode of continent voiding).	2 560	corrected	11/18/16

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2 560	Continued From page 3 Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence care plan initiated until 10/19/16. Review of R13's NAR (nursing assistant) daily assignment sheet, dated October 19, 2016 revealed the following: "Incontinence: No; Incontinent Products:[blank]; Able to communicate the need to void-Uses call light." R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistant, (NA)-C was observed assisting R13 to pull incontinence brief and pants down and sit on the toilet. R13 noted her incontinence brief was wet. NA-C then assisted R13 with providing perineal care. After assisting R13 with toileting, NA-C reported R13's incontinence brief was wet today and she assisted with providing perineal care. NA-C reported R13 was able to inform staff when she needed to use the toilet. On 10/19/16, at 1:32 p.m. registered nurses (RN)-B and (RN)-C confirmed there was no comprehensive care plan for urinary incontinence for R13. RN-C and RN-B reviewed the NAR (nursing assistant) daily assignment sheet and explained it was a care guide for the nursing assistants, not a comprehensive care plan. RN-B and RN-C confirmed the daily assignment sheet indicated R13 did not experience incontinence, did not wear an incontinence brief and was able to communicate the need to void. When asked if the daily assignment sheet was accurate, RN-C shrugged her shoulders. RN-B and RN-C reported the daily assignment sheets were frequently changed and past copies were not retained.	2 560		

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2 560	Continued From page 4 The Bowel and Bladder Assessment Policy, undated, directed staff: "Upon identifying resident's program, an appropriate plan of care will be implemented. Resident's individual toileting program will be on the nursing assistant's care sheets and resident care plan." Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R13) reviewed for urinary incontinence. Findings include: R13's admission Minimum Data Set (MDS), dated 6/12/16, revealed R13 was occasionally incontinent (less than 7 documented episodes of incontinence). R13's quarterly MDS, dated 9/10/16, revealed R13 was frequently incontinent (more than 7 documented episodes of incontinence, but at least one episode of continent voiding). Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence care plan initiated until 10/19/16. Review of R13's NAR (nursing assistant) daily assignment sheet, dated October 19, 2016 revealed the following: "Incontinence: No; Incontinent Products:[blank]; Able to communicate the need to void-Uses call light."	2 560		

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2 560	Continued From page 5 R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistant, (NA)-C was observed assisting R13 to pull incontinence brief and pants down and sit on the toilet. R13 noted her incontinence brief was wet. NA-C then assisted R13 with providing perineal care. After assisting R13 with toileting, NA-C reported R13's incontinence brief was wet today and she assisted with providing perineal care. NA-C reported R13 was able to inform staff when she needed to use the toilet. On 10/19/16, at 1:32 p.m. registered nurses (RN)-B and (RN)-C confirmed there was no comprehensive care plan for urinary incontinence for R13. RN-C and RN-B reviewed the NAR (nursing assistant) daily assignment sheet and explained it was a care guide for the nursing assistants, not a comprehensive care plan. RN-B and RN-C confirmed the daily assignment sheet indicated R13 did not experience incontinence, did not wear an incontinence brief and was able to communicate the need to void. When asked if the daily assignment sheet was accurate, RN-C shrugged her shoulders. RN-B and RN-C reported the daily assignment sheets were frequently changed and past copies were not retained. The Bowel and Bladder Assessment Policy, undated, directed staff: "Upon identifying resident's program, an appropriate plan of care will be implemented. Resident's individual toileting program will be on the nursing assistant's care sheets and resident care plan." SUGGESTED METHOD FOR CORRECTION:	2 560		

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2 560	Continued From page 6 The director of nursing or designee could direct staff to develop a care plan to include identification of all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan related to activities of daily living (ADLs) for 1 of 3 residents (R54) reviewed for ADLs. Findings include: On 10/19/16, at 9:48 a.m. nursing assistant (NA)-A was noted to wheel R54 from the dining room to her bedroom, near her bed. NA-A put transfer belt around R54's waist and said "can you give me a hug?, can you hold onto me?", then assisted R54 to a standing position and pivoted her to her bed and to lay down. NA-A then assisted R54 to roll onto her side to pull her pants down and remove her incontinence brief. NA-A then cleaned R54's bottom with toilet paper. No	2 565	corrected	11/18/16

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2 565	Continued From page 7 other staff was present to assist R54. R54 moaned quietly while being transferred, turned and assisted with brief changes and peri-care. On 10/19/16, at 10:56 a.m. NA-A reported R54 needed assistance from 1-2 staff for bed mobility, transfers and toileting, depending on how she was doing. R54's NAR (nursing assistant) daily assignments, dated 10/19/16, directed staff: "Transferring: 2 Assist" and "Bed Mobility: 2 Assist." R54's care plan, last revised 10/17/16, directed staff: "The resident has an ADL self-care performance deficit r/t (related to) terminal Alzheimer's disease." and "Bed Mobility: The resident requires physical assistance by 2 staff to turn, reposition and boost up in bed." and "Toilet Use: The resident requires physical assistance by 2 staff for dignity toileting." and "Transfer: The resident requires physical assistance of 1-2 staff with pivot transfers." The care plan, last revised 10/20/16, further directed staff "Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface." On 10/19/2016, at 1:30 p.m., RN-C confirmed R54 required assistance of 1-2 staff for transfers and assistance of 2 staff for toileting and bed mobility per R54's care plan. RN-C reported nursing assistants should follow directions on the NAR daily assignment sheet. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan implementation. The DON or	2 565		

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2 565	Continued From page 8 designee, could provide training for all nursing staff related to following the care plan. The quality assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents reviewed for urinary incontinence (R13) was provided with the services necessary to achieve the highest practicable level of bladder function. Findings include:	2 910	corrected	11/23/16

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2 910	Continued From page 9 R13's admission Minimum Data Set (MDS), dated 6/12/16, revealed R13 was occasionally incontinent (less than 7 documented episodes of incontinence) and required limited assistance for toilet use. R13's quarterly MDS, dated 9/10/16, revealed R13 was frequently incontinent (more than 7 documented episodes of incontinence, but at least one episode of continent voiding) and required extensive assistance for toilet use. R13's urinary care area assessment, dated 6/15/16, revealed "Resident had 2 documented episodes of incontinence during observation period and was highly involved in toileting task but did receive physical assistance for management of clothing, transfers to toilet, and peri-care with incontinence episodes. Resident wears a pull up at all times." Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence care plan initiated until 10/19/16. Review of R13's NAR (nursing assistant) daily assignment sheet, dated October 19, 2016 revealed the following: "Incontinence: No; Incontinent Products:[blank]; Able to communicate the need to void-Uses call light." R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistant, (NA)-C was observed assisting R13 to pull incontinence brief and pants down and sit on the toilet. R13 noted her incontinence brief was wet. NA-C then assisted R13 with providing perineal care. After assisting R13 with toileting, NA-C reported R13's incontinence brief was wet today and she assisted with providing perineal care.	2 910		

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2 910	Continued From page 10 NA-C reported R13 was able to inform staff when she needed to use the toilet. On 10/19/16, at 1:32 p.m. registered nurses (RN)-B and (RN)-C confirmed R13 went from occasionally incontinent on the admission MDS, dated 6/12/16, and frequently incontinent for the MDS, dated 9/10/16. RN-B and RN-C were unable to articulate the reason R13 declined in bladder function. RN-B and RN-C reported there was no comprehensive care plan for urinary incontinence for R13. RN-C and RN-B reviewed the NAR (nursing assistant) daily assignment sheet and explained it was a care guide for the nursing assistants, not a comprehensive care plan. RN-B and RN-C confirmed the daily assignment sheet indicated R13 did not experience incontinence, did not wear an incontinence brief and was able to communicate the need to void. When asked if the daily assignment sheet was accurate, RN-C shrugged her shoulders. RN-B and RN-C reported the daily assignment sheets were frequently changed and past copies were not retained. The Bowel and Bladder Assessment Policy, undated, directed staff: "Upon identifying resident's program, an appropriate plan of care will be implemented. Resident's individual toileting program will be on the nursing assistant's care sheets and resident care plan." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include identification of all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs.	2 910		

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2 910	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services related to activities of daily living (ADLs) for 1 of 3 residents (R54) reviewed for ADLs. Findings include: R54's most recent Minimum Data Set (MDS), dated 8/28/16, revealed R54 had both long and short term memory problems as well as no recall ability and severely impaired decision making. The MDS further indicated R54 required extensive assistance from two staff for bed mobility, transfers and toileting. On 10/19/16, at 9:48 a.m. nursing assistant (NA)-A was noted to wheel R54 from the dining room to her bedroom, near her bed. NA-A put transfer belt around R54's waist and said "can you give me a hug?, can you hold onto me?", then assisted R54 to a standing position and	2 920	corrected	11/23/16

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2 920	Continued From page 12 pivoted her to her bed and to lay down. NA-A then assisted R54 to roll onto her side to pull her pants down and remove her incontinence brief. NA-A then cleaned R54's bottom with toilet paper. No other staff was present to assist R54. R54 moaned quietly while being transferred, turned and assisted with brief changes and peri-care. On 10/19/16, at 10:56 a.m. NA-A reported R54 needed assistance from 1-2 staff for bed mobility, transfers and toileting, depending on how she was doing. R54's care area assessment, dated 9/2/16, revealed "Resident is no longer ambulatory and requires staff assist with all ADL's (activities of daily living). Receives physical staff assist with all bed mobility and transfers." and "Requires extensive to total staff assistance for all toileting tasks including peri-care, brief change, and clothing adjustment." R54's NAR [nursing assistant] daily assignments, dated 10/19/16, directed staff: "Transferring: 2 Assist" and "Bed Mobility: 2 Assist." R54's care plan, last revised 10/17/16, directed staff: "The resident has an ADL self-care performance deficit r/t (related to) terminal Alzheimer's disease." and "Bed Mobility: The resident requires physical assistance by 2 staff to turn, reposition and boost up in bed." and "Toilet Use: The resident requires physical assistance by 2 staff for dignity toileting." and "Transfer: The resident requires physical assistance of 1-2 staff with pivot transfers." The care plan, last revised 10/20/16, further directed staff "Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface."	2 920		

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	00997	A. BUILDING: _____ B. WING _____	10/20/2016

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2 920	Continued From page 13 On 10/19/2016 at 1:30 p.m., RN-C confirmed R54 required assistance of 1-2 staff for transfers and assistance of 2 staff for toileting and bed mobility. RN-C reported nursing assistants should follow directions on the NAR daily assignment sheet. If a nursing assistant noticed residents needed a different level of care than on the NAR daily assignment sheet, the nursing assistant should inform the nurse on the unit. The nurse should then re-evaluate and consult with occupational or physical therapy as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing could re-educate all staff to follow care plans in regards to specific resident cares and services, and could develop a system to audit and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen and ice machines were maintained in a clean and sanitary manner. This had the potential to affect residents who were served food and or ice,	21015	corrected	11/10/16

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21015	Continued From page 14 related to the deficiencies noted below. Findings include: On 10/17/16, at 12:30 p.m. fruit flies were observed to be flying around near sandwiches on the counter. There was a heavy buildup of crumbs and dust on the dishwasher. A disposable pan was noted to be washed and put on the drying counter. The clean dishes drying counter, above the clean dishes from the dishwasher, was noted to have blue plastic peeling off the metal racks. On 10/20/16, at 10:10 a.m. the dietary supervisor (DS) confirmed a heavy buildup of orange and brown crumbs and dust on top of the dishwasher. DS sprayed the top of the dishwasher and wiped with a rag, which caused dust and crumbs to fall on the clean dish side. DS was not sure what the buildup of crumbs and dust were from. DS confirmed the disposable pans were washed and reused for serving hot food. DS confirmed the drying racks had blue plastic peeling from the metal. The first floor ice machine was noted to have orange buildup on the upper side of the machine. It was full of ice. On the 2nd floor, the ice and water machines had white, yellow, orange and red in the ice and water chutes and on the tray under the chutes. DS reported she did not monitor the cleaning and maintenance of the ice and water machines. The housekeeping manager reported housekeepers just wipe the outside of the ice and water machines. The maintenance manager (MM) reported he cleaned the inside of the 1st floor ice bin about every 6 months but did not have a cleaning procedure for the 2nd floor ice and water machine. MM confirmed buildup of white, yellow, orange and red substance in the ice	21015		

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21015	Continued From page 15 and water chutes and tray below. MM was not able to provide manufacturer recommendations for cleaning the 2nd floor ice and water machine. The Ice Machine and Refrigerators Policy, undated, directed staff "1. Wash outside surfaces daily. 2. Rinse and dry." An email from the food and kitchen equipment supplier, printed 10/20/16, noted "those aluminum pans are NOT meant to be reused." A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise cleaning policies and procedures to assure that food equipment is maintained in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor food equipment cleanliness on a periodic basis. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure pneumococcal vaccines were offered to 5 of 5 residents (R20, R40, R36,	21375	corrected	11/30/16

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21375	Continued From page 16 R43, R6) whose immunization records were reviewed. In addition, the facility failed to develop accurate guidelines for Pneumococcal Conjugate Vaccine (PCV)-13 as recommended by the Centers for Disease Control (CDC). In addition, based on observation, interview and document review, the facility failed to ensure proper handwashing during cares for 2 of 4 (R54, R59) residents reviewed for personal cares. Finding include: R20 admitted to the facility on 10/27/12. Immunization records revealed the resident had received pneumococcal polysaccharide vaccination (PPV-23) on 5/4/07. There was no indication the PCV-13 and second dose of PPSV 23 had been offered to R20. R40 admitted to the facility on 5/8/14. Immunization records revealed resident received a PPSV-23 on 01/20/04, however, the medical record lacked evidence R40 was offered the second dose of PPSV 23 as well as PCV-13. R36 admitted to the facility on 3/20/08. Immunization records revealed R36 received a PPSV-23 on 10/25/05; however, the medical record lacked evidence R36 was offered the second dose of PPSV 23 and PCV-13. R43 was 97 years old, and was admitted to the facility on 9/21/11. Immunization records indicated R43 received a PPSV-23 on 7/4/08; however, the medical record lacked evidence R43was offered the second dose of PPSV 23 and PCV-13. R6 admitted to the facility on 7/15/15. Immunization records revealed R6 had received	21375		

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21375	Continued From page 17	21375		

pneumococcal polysaccharide vaccination PPV-23 on 10/18/06. There was no indication PCV-13 and the second dose of PPSV 23 had been offered to R6.

During interview with assistant director of nursing (ADON) on 10/20/16, at 9:29 a.m. ADON stated "I know you are asking me about the Pneumovax but we did not update our system yet."

During interview with the Director of nursing (DON) on 10/20/16, at 12:07 p.m. The DON stated "we are work in progress,we do not have an actual policy approved by the facility in place, but at this point we are going with the physician directive and recommendation, it is something we are looking into, ADON got the training last week and she put this policy in place but needs to be reviewed. We are planning to incorporate all the pneumococcal vaccination as recommended."

Policy: Undated policy titled, "Policy for Pneumococcal immunization" indicated "Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized.... the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. Vaccine received resident will receive either PCV 13 (Prevnar 13) or PPSV 23 (Pneumovax 23).... Resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal."

Handwashing:

On 10/19/16, at 9:48 a.m. nursing assistant

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(NA)-B removed R54's soiled incontinence brief and applied a new brief with gloved hands. NA-B noted R54 was continuing to produce a bowel movement so she would come back and change R54 again shortly. NA-B then gathered the bag of soiled incontinence brief and toilet paper, went into the bathroom and came right back out within 10 seconds to R54. NA-B was not wearing gloves. NA-B then put the blanket on R54, moved her call light and R54's hands near the call light. NA-B then opened the door and went into the nearby room to wash hands. NA-B confirmed she removed her gloves but did not wash her hands until after she left the room.

On 10/18/16, at 9:42 a.m. NA-A and NA-D were observed assisting R59 from his wheelchair into a mechanical standing lift. NA-A assisted R59 with sitting upright while NA-D placed leg straps up. NA-A and NA-D then assisted R59 with standing up with use of the mechanical standing lift and move him into the bathroom, assisted him with removing pants and incontinence brief and pulling pants down and helped him sit on the toilet. NA-D washed her hands for five seconds, then wiped them on her pants to dry them. NA-D then left the room. NA-A remained in the room to supervise R59. R59 had a bowel movement in the toilet. At 10:12 a.m. NA-D returned to assist R59 stand near the toilet as NA-A wiped R59's perineal area, applied a brief and pulled his pants back up. NA-A removed her gloves but did not wash or sanitize hands. NA-D and NA-A moved R59 from the toilet to the bed and to sit and rest in his bed. NA-A and NA-D then removed R59's shoes. NA-D straightened the blankets on R59's bed, placed a wedge under R59's legs and moved a floor mat into place near R59's bed. NA-D then removed her gloves and washed her hands for five seconds, dried with paper towel and left the

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21375	Continued From page 19 room. NA-A called for the nurse and then exited the room with garbage and washed her hands in the staff bathroom. On 10/19/16, at 10:47 a.m. the assistant director of nursing (RN)-E reported she would expect nursing assistants to wash or sanitize hands according to how they were trained per the policy and procedure and hand sanitizer was available to use as appropriate. The Handwashing policy, updated 3/19/12, directed staff "Wet hands with running water. 2. Apply soap and thoroughly disperse over hands. 3. Vigorously rub hands together for 10-15 seconds generating friction on all surfaces including under fingernails. 4. Rinse thoroughly. 5. Pat dry thoroughly with paper towels. 6. Turn faucet off using a paper towel to protect hands from dirty faucet. 7. Dispose of paper towel in waste basket. 8. Hands are to be washed before and after providing personal cares for a resident, between residents, before leaving a dirty area and entering a clean area, after removing gloves, etc. Hand hygiene may also be performed with the use of antiseptic hand rub as follows: 1. Make sure all organic matter is removed from hands (i.e. visible dirt) 2. Apply a dime sized amount of hand sanitizer to the palm of one hand or use a waterless hand sanitizer wipe. 3. Rub hands together covering all surfaces of hands and fingers. Rub until hand sanitizer is absorbed. 4. Wash hands with soap and water after every 10-15 uses of hand sanitizer." SUGGESTED METHOD OF CORRECTION: The director of nursing and infection control nurse could review the Pneumococcal policies and procedures to ensure all required information is	21375		

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21375	Continued From page 20 included. Appropriate staff could be educated regarding requirements. Audits could be could be conducted and the results reviewed at the quality committee meetings. The director of nursing or designee could assure that hand washing policies are reviewed, staff re-trained to assure proper handwashing is conducted when providing care to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 17, 18, 19 and 20th, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. An investigation of complaint H5063014 was completed and found not to be substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R13) reviewed for urinary incontinence. Findings include: R13's admission Minimum Data Set (MDS), dated 6/12/16, revealed R13 was occasionally incontinent (less than 7 documented episodes of incontinence). R13's quarterly MDS, dated 9/10/16, revealed R13 was frequently incontinent (more than 7 documented episodes of incontinence, but at least one episode of continent voiding).	2 560		

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2 560	Continued From page 3 Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence care plan initiated until 10/19/16. Review of R13's NAR (nursing assistant) daily assignment sheet, dated October 19, 2016 revealed the following: "Incontinence: No; Incontinent Products:[blank]; Able to communicate the need to void-Uses call light." R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistant, (NA)-C was observed assisting R13 to pull incontinence brief and pants down and sit on the toilet. R13 noted her incontinence brief was wet. NA-C then assisted R13 with providing perineal care. After assisting R13 with toileting, NA-C reported R13's incontinence brief was wet today and she assisted with providing perineal care. NA-C reported R13 was able to inform staff when she needed to use the toilet. On 10/19/16, at 1:32 p.m. registered nurses (RN)-B and (RN)-C confirmed there was no comprehensive care plan for urinary incontinence for R13. RN-C and RN-B reviewed the NAR (nursing assistant) daily assignment sheet and explained it was a care guide for the nursing assistants, not a comprehensive care plan. RN-B and RN-C confirmed the daily assignment sheet indicated R13 did not experience incontinence, did not wear an incontinence brief and was able to communicate the need to void. When asked if the daily assignment sheet was accurate, RN-C shrugged her shoulders. RN-B and RN-C reported the daily assignment sheets were frequently changed and past copies were not retained.	2 560		

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2 560	Continued From page 4 The Bowel and Bladder Assessment Policy, undated, directed staff: "Upon identifying resident's program, an appropriate plan of care will be implemented. Resident's individual toileting program will be on the nursing assistant's care sheets and resident care plan." Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R13) reviewed for urinary incontinence. Findings include: R13's admission Minimum Data Set (MDS), dated 6/12/16, revealed R13 was occasionally incontinent (less than 7 documented episodes of incontinence). R13's quarterly MDS, dated 9/10/16, revealed R13 was frequently incontinent (more than 7 documented episodes of incontinence, but at least one episode of continent voiding). Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence care plan initiated until 10/19/16. Review of R13's NAR (nursing assistant) daily assignment sheet, dated October 19, 2016 revealed the following: "Incontinence: No; Incontinent Products:[blank]; Able to communicate the need to void-Uses call light."	2 560		

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ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 5 R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistant, (NA)-C was observed assisting R13 to pull incontinence brief and pants down and sit on the toilet. R13 noted her incontinence brief was wet. NA-C then assisted R13 with providing perineal care. After assisting R13 with toileting, NA-C reported R13's incontinence brief was wet today and she assisted with providing perineal care. NA-C reported R13 was able to inform staff when she needed to use the toilet. On 10/19/16, at 1:32 p.m. registered nurses (RN)-B and (RN)-C confirmed there was no comprehensive care plan for urinary incontinence for R13. RN-C and RN-B reviewed the NAR (nursing assistant) daily assignment sheet and explained it was a care guide for the nursing assistants, not a comprehensive care plan. RN-B and RN-C confirmed the daily assignment sheet indicated R13 did not experience incontinence, did not wear an incontinence brief and was able to communicate the need to void. When asked if the daily assignment sheet was accurate, RN-C shrugged her shoulders. RN-B and RN-C reported the daily assignment sheets were frequently changed and past copies were not retained. The Bowel and Bladder Assessment Policy, undated, directed staff: "Upon identifying resident's program, an appropriate plan of care will be implemented. Resident's individual toileting program will be on the nursing assistant's care sheets and resident care plan." SUGGESTED METHOD FOR CORRECTION:	2 560		

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2 560	Continued From page 6 The director of nursing or designee could direct staff to develop a care plan to include identification of all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan related to activities of daily living (ADLs) for 1 of 3 residents (R54) reviewed for ADLs. Findings include: On 10/19/16, at 9:48 a.m. nursing assistant (NA)-A was noted to wheel R54 from the dining room to her bedroom, near her bed. NA-A put transfer belt around R54's waist and said "can you give me a hug?, can you hold onto me?", then assisted R54 to a standing position and pivoted her to her bed and to lay down. NA-A then assisted R54 to roll onto her side to pull her pants down and remove her incontinence brief. NA-A then cleaned R54's bottom with toilet paper. No	2 565		

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2 565	Continued From page 7	2 565		

other staff was present to assist R54. R54 moaned quietly while being transferred, turned and assisted with brief changes and peri-care.

On 10/19/16, at 10:56 a.m. NA-A reported R54 needed assistance from 1-2 staff for bed mobility, transfers and toileting, depending on how she was doing.

R54's NAR (nursing assistant) daily assignments, dated 10/19/16, directed staff: "Transferring: 2 Assist" and "Bed Mobility: 2 Assist."

R54's care plan, last revised 10/17/16, directed staff: "The resident has an ADL self-care performance deficit r/t (related to) terminal Alzheimer's disease." and "Bed Mobility: The resident requires physical assistance by 2 staff to turn, reposition and boost up in bed." and "Toilet Use: The resident requires physical assistance by 2 staff for dignity toileting." and "Transfer: The resident requires physical assistance of 1-2 staff with pivot transfers." The care plan, last revised 10/20/16, further directed staff "Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface."

On 10/19/2016, at 1:30 p.m., RN-C confirmed R54 required assistance of 1-2 staff for transfers and assistance of 2 staff for toileting and bed mobility per R54's care plan. RN-C reported nursing assistants should follow directions on the NAR daily assignment sheet.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan implementation. The DON or

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2 565	Continued From page 8 designee, could provide training for all nursing staff related to following the care plan. The quality assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents reviewed for urinary incontinence (R13) was provided with the services necessary to achieve the highest practicable level of bladder function. Findings include:	2 910		

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2 910	Continued From page 9 R13's admission Minimum Data Set (MDS), dated 6/12/16, revealed R13 was occasionally incontinent (less than 7 documented episodes of incontinence) and required limited assistance for toilet use. R13's quarterly MDS, dated 9/10/16, revealed R13 was frequently incontinent (more than 7 documented episodes of incontinence, but at least one episode of continent voiding) and required extensive assistance for toilet use. R13's urinary care area assessment, dated 6/15/16, revealed "Resident had 2 documented episodes of incontinence during observation period and was highly involved in toileting task but did receive physical assistance for management of clothing, transfers to toilet, and peri-care with incontinence episodes. Resident wears a pull up at all times." Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence care plan initiated until 10/19/16. Review of R13's NAR (nursing assistant) daily assignment sheet, dated October 19, 2016 revealed the following: "Incontinence: No; Incontinent Products:[blank]; Able to communicate the need to void-Uses call light." R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistant, (NA)-C was observed assisting R13 to pull incontinence brief and pants down and sit on the toilet. R13 noted her incontinence brief was wet. NA-C then assisted R13 with providing perineal care. After assisting R13 with toileting, NA-C reported R13's incontinence brief was wet today and she assisted with providing perineal care.	2 910		

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2 910	Continued From page 10 NA-C reported R13 was able to inform staff when she needed to use the toilet. On 10/19/16, at 1:32 p.m. registered nurses (RN)-B and (RN)-C confirmed R13 went from occasionally incontinent on the admission MDS, dated 6/12/16, and frequently incontinent for the MDS, dated 9/10/16. RN-B and RN-C were unable to articulate the reason R13 declined in bladder function. RN-B and RN-C reported there was no comprehensive care plan for urinary incontinence for R13. RN-C and RN-B reviewed the NAR (nursing assistant) daily assignment sheet and explained it was a care guide for the nursing assistants, not a comprehensive care plan. RN-B and RN-C confirmed the daily assignment sheet indicated R13 did not experience incontinence, did not wear an incontinence brief and was able to communicate the need to void. When asked if the daily assignment sheet was accurate, RN-C shrugged her shoulders. RN-B and RN-C reported the daily assignment sheets were frequently changed and past copies were not retained. The Bowel and Bladder Assessment Policy, undated, directed staff: "Upon identifying resident's program, an appropriate plan of care will be implemented. Resident's individual toileting program will be on the nursing assistant's care sheets and resident care plan." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include identification of all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs.	2 910		

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2 910	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services related to activities of daily living (ADLs) for 1 of 3 residents (R54) reviewed for ADLs. Findings include: R54's most recent Minimum Data Set (MDS), dated 8/28/16, revealed R54 had both long and short term memory problems as well as no recall ability and severely impaired decision making. The MDS further indicated R54 required extensive assistance from two staff for bed mobility, transfers and toileting. On 10/19/16, at 9:48 a.m. nursing assistant (NA)-A was noted to wheel R54 from the dining room to her bedroom, near her bed. NA-A put transfer belt around R54's waist and said "can you give me a hug?, can you hold onto me?", then assisted R54 to a standing position and	2 920		

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2 920	Continued From page 12 pivoted her to her bed and to lay down. NA-A then assisted R54 to roll onto her side to pull her pants down and remove her incontinence brief. NA-A then cleaned R54's bottom with toilet paper. No other staff was present to assist R54. R54 moaned quietly while being transferred, turned and assisted with brief changes and peri-care. On 10/19/16, at 10:56 a.m. NA-A reported R54 needed assistance from 1-2 staff for bed mobility, transfers and toileting, depending on how she was doing. R54's care area assessment, dated 9/2/16, revealed "Resident is no longer ambulatory and requires staff assist with all ADL's (activities of daily living). Receives physical staff assist with all bed mobility and transfers." and "Requires extensive to total staff assistance for all toileting tasks including peri-care, brief change, and clothing adjustment." R54's NAR [nursing assistant] daily assignments, dated 10/19/16, directed staff: "Transferring: 2 Assist" and "Bed Mobility: 2 Assist." R54's care plan, last revised 10/17/16, directed staff: "The resident has an ADL self-care performance deficit r/t (related to) terminal Alzheimer's disease." and "Bed Mobility: The resident requires physical assistance by 2 staff to turn, reposition and boost up in bed." and "Toilet Use: The resident requires physical assistance by 2 staff for dignity toileting." and "Transfer: The resident requires physical assistance of 1-2 staff with pivot transfers." The care plan, last revised 10/20/16, further directed staff "Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface."	2 920		

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2 920	Continued From page 13 On 10/19/2016 at 1:30 p.m., RN-C confirmed R54 required assistance of 1-2 staff for transfers and assistance of 2 staff for toileting and bed mobility. RN-C reported nursing assistants should follow directions on the NAR daily assignment sheet. If a nursing assistant noticed residents needed a different level of care than on the NAR daily assignment sheet, the nursing assistant should inform the nurse on the unit. The nurse should then re-evaluate and consult with occupational or physical therapy as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing could re-educate all staff to follow care plans in regards to specific resident cares and services, and could develop a system to audit and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen and ice machines were maintained in a clean and sanitary manner. This had the potential to affect residents who were served food and or ice,	21015		

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21015	Continued From page 14 related to the deficiencies noted below. Findings include: On 10/17/16, at 12:30 p.m. fruit flies were observed to be flying around near sandwiches on the counter. There was a heavy buildup of crumbs and dust on the dishwasher. A disposable pan was noted to be washed and put on the drying counter. The clean dishes drying counter, above the clean dishes from the dishwasher, was noted to have blue plastic peeling off the metal racks. On 10/20/16, at 10:10 a.m. the dietary supervisor (DS) confirmed a heavy buildup of orange and brown crumbs and dust on top of the dishwasher. DS sprayed the top of the dishwasher and wiped with a rag, which caused dust and crumbs to fall on the clean dish side. DS was not sure what the buildup of crumbs and dust were from. DS confirmed the disposable pans were washed and reused for serving hot food. DS confirmed the drying racks had blue plastic peeling from the metal. The first floor ice machine was noted to have orange buildup on the upper side of the machine. It was full of ice. On the 2nd floor, the ice and water machines had white, yellow, orange and red in the ice and water chutes and on the tray under the chutes. DS reported she did not monitor the cleaning and maintenance of the ice and water machines. The housekeeping manager reported housekeepers just wipe the outside of the ice and water machines. The maintenance manager (MM) reported he cleaned the inside of the 1st floor ice bin about every 6 months but did not have a cleaning procedure for the 2nd floor ice and water machine. MM confirmed buildup of white, yellow, orange and red substance in the ice	21015		

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21015	Continued From page 15 and water chutes and tray below. MM was not able to provide manufacturer recommendations for cleaning the 2nd floor ice and water machine. The Ice Machine and Refrigerators Policy, undated, directed staff "1. Wash outside surfaces daily. 2. Rinse and dry." An email from the food and kitchen equipment supplier, printed 10/20/16, noted "those aluminum pans are NOT meant to be reused." A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise cleaning policies and procedures to assure that food equipment is maintained in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor food equipment cleanliness on a periodic basis. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure pneumococcal vaccines were offered to 5 of 5 residents (R20, R40, R36,	21375		

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21375	Continued From page 16	21375		

R43, R6) whose immunization records were reviewed. In addition, the facility failed to develop accurate guidelines for Pneumococcal Conjugate Vaccine (PCV)-13 as recommended by the Centers for Disease Control (CDC). In addition, based on observation, interview and document review, the facility failed to ensure proper handwashing during cares for 2 of 4 (R54, R59) residents reviewed for personal cares.

Finding include:

R20 admitted to the facility on 10/27/12. Immunization records revealed the resident had received pneumococcal polysaccharide vaccination (PPV-23) on 5/4/07. There was no indication the PCV-13 and second dose of PPSV 23 had been offered to R20.

R40 admitted to the facility on 5/8/14. Immunization records revealed resident received a PPSV-23 on 01/20/04, however, the medical record lacked evidence R40 was offered the second dose of PPSV 23 as well as PCV-13.

R36 admitted to the facility on 3/20/08. Immunization records revealed R36 received a PPSV-23 on 10/25/05; however, the medical record lacked evidence R36 was offered the second dose of PPSV 23 and PCV-13.

R43 was 97 years old, and was admitted to the facility on 9/21/11. Immunization records indicated R43 received a PPSV-23 on 7/4/08; however, the medical record lacked evidence R43was offered the second dose of PPSV 23 and PCV-13.

R6 admitted to the facility on 7/15/15. Immunization records revealed R6 had received

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pneumococcal polysaccharide vaccination PPV-23 on 10/18/06. There was no indication PCV-13 and the second dose of PPSV 23 had been offered to R6.

During interview with assistant director of nursing (ADON) on 10/20/16, at 9:29 a.m. ADON stated "I know you are asking me about the Pneumovax but we did not update our system yet."

During interview with the Director of nursing (DON) on 10/20/16, at 12:07 p.m. The DON stated "we are work in progress,we do not have an actual policy approved by the facility in place, but at this point we are going with the physician directive and recommendation, it is something we are looking into, ADON got the training last week and she put this policy in place but needs to be reviewed. We are planning to incorporate all the pneumococcal vaccination as recommended."

Policy: Undated policy titled, "Policy for Pneumococcal immunization" indicated "Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized.... the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. Vaccine received resident will receive either PCV 13 (Prevnar 13) or PPSV 23 (Pneumovax 23).... Resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal."

Handwashing:

On 10/19/16, at 9:48 a.m. nursing assistant

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(NA)-B removed R54's soiled incontinence brief and applied a new brief with gloved hands. NA-B noted R54 was continuing to produce a bowel movement so she would come back and change R54 again shortly. NA-B then gathered the bag of soiled incontinence brief and toilet paper, went into the bathroom and came right back out within 10 seconds to R54. NA-B was not wearing gloves. NA-B then put the blanket on R54, moved her call light and R54's hands near the call light. NA-B then opened the door and went into the nearby room to wash hands. NA-B confirmed she removed her gloves but did not wash her hands until after she left the room.

On 10/18/16, at 9:42 a.m. NA-A and NA-D were observed assisting R59 from his wheelchair into a mechanical standing lift. NA-A assisted R59 with sitting upright while NA-D placed leg straps up. NA-A and NA-D then assisted R59 with standing up with use of the mechanical standing lift and move him into the bathroom, assisted him with removing pants and incontinence brief and pulling pants down and helped him sit on the toilet. NA-D washed her hands for five seconds, then wiped them on her pants to dry them. NA-D then left the room. NA-A remained in the room to supervise R59. R59 had a bowel movement in the toilet. At 10:12 a.m. NA-D returned to assist R59 stand near the toilet as NA-A wiped R59's perineal area, applied a brief and pulled his pants back up. NA-A removed her gloves but did not wash or sanitize hands. NA-D and NA-A moved R59 from the toilet to the bed and to sit and rest in his bed. NA-A and NA-D then removed R59's shoes. NA-D straightened the blankets on R59's bed, placed a wedge under R59's legs and moved a floor mat into place near R59's bed. NA-D then removed her gloves and washed her hands for five seconds, dried with paper towel and left the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00997	A. BUILDING: _____ B. WING _____	10/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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room. NA-A called for the nurse and then exited the room with garbage and washed her hands in the staff bathroom.

On 10/19/16, at 10:47 a.m. the assistant director of nursing (RN)-E reported she would expect nursing assistants to wash or sanitize hands according to how they were trained per the policy and procedure and hand sanitizer was available to use as appropriate.

The Handwashing policy, updated 3/19/12, directed staff "Wet hands with running water. 2. Apply soap and thoroughly disperse over hands. 3. Vigorously rub hands together for 10-15 seconds generating friction on all surfaces including under fingernails. 4. Rinse thoroughly. 5. Pat dry thoroughly with paper towels. 6. Turn faucet off using a paper towel to protect hands from dirty faucet. 7. Dispose of paper towel in waste basket. 8. Hands are to be washed before and after providing personal cares for a resident, between residents, before leaving a dirty area and entering a clean area, after removing gloves, etc. Hand hygiene may also be performed with the use of antiseptic hand rub as follows: 1. Make sure all organic matter is removed from hands (i.e. visible dirt) 2. Apply a dime sized amount of hand sanitizer to the palm of one hand or use a waterless hand sanitizer wipe. 3. Rub hands together covering all surfaces of hands and fingers. Rub until hand sanitizer is absorbed. 4. Wash hands with soap and water after every 10-15 uses of hand sanitizer."

SUGGESTED METHOD OF CORRECTION: The director of nursing and infection control nurse could review the Pneumococcal policies and procedures to ensure all required information is

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21375	Continued From page 20 included. Appropriate staff could be educated regarding requirements. Audits could be could be conducted and the results reviewed at the quality committee meetings. The director of nursing or designee could assure that hand washing policies are reviewed, staff re-trained to assure proper handwashing is conducted when providing care to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		