#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: G1TQ

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART	I - TO BE COMPLE	TED BY THE STA	ATE SURVEY AGENCY	Facility ID: 00997		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245063 2.STATE VENDOR OR MEDICAID NO. (L2) 491343400	3. NAME AND ADDRESS (L3) ST ANTHONY PA (L4) 2237 COMMONW (L5) SAINT PAUL, MN	ARK HOME VEALTH AVENUE	(L6) 55108	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER		02 (L7) D 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint		
6. DATE OF SURVEY 12/05/2016 (L34)  8. ACCREDITATION STATUS: (L10)  0 Unaccredited 1 TJC 2 AOA 3 Other	03 SNF/NF/Distinct 07	5 PRTF 10 NF 7 X-Ray 11 ICF/ 3 OPT/SP 12 RHC		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 CEI  X A. In Compliance Wi Program Requirem Compliance Based1. Accepta  B. Not in Compliance Requirements and/or	ith nents I On: able POC e with Program	And/Or Approved Waivers Of The  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNF)  5. Life Safety Code  * Code: A*	Following Requirements:		
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF  84  (L37) (L38) (L39)	ICF (L42)	IID (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
6. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):  7. SURVEYOR SIGNATURE  Date:  18. STATE SURVEY AGENCY APPROVAL  Date:  Kate JohnsTon, Program Specialist  12/19/2016  (L19)						
PART II - TO	BE COMPLETED BY	HCFA REGION	AL OFFICE OR SINGLE STAT			
19. DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate  2. Facility is not Eligible  (L21)	20. COMPLIA! RIGHTS AG	NCE WITH CIVIL CT:	1. Statement of Financi     2. Ownership/Control I     3. Both of the Above :	al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)		
22. ORIGINAL DATE  OF PARTICIPATION  01/04/1967  (L24)  23. LTC AGREEM  BEGINNING  (L41)	DATE EI	C AGREEMENT NDING DATE	26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimbursement  03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE:  27. ALTERNATIV  A. Suspension  (L27)  B. Rescind Sus	of Admissions:	(L44) (L45)	04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
28. TERMINATION DATE: 29	. INTERMEDIARY/CARRII 03001	ER NO. (L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539 32 (L32)	DETERMINATION OF API	PROVAL DATE (L33)	Posted 12/27/2016 Co.  DETERMINATION APPRO	VAL		



#### 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.

St Anthony Park Home December 19, 2016 Page 2

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



#### 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.

St Anthony Park Home December 19, 2016 Page 2

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

		POST	-CERT	TFICATIO	N REVISIT R	EPORT			
	R / SUPPLIER / CLIA /	MULTIPLE CONS	STRUCTION					DATE (	OF REVISIT
245063	CATION NUMBER Y1	A. Building B. Wing					Y	, 12/5/2	016 <sub>Y3</sub>
NAME OF	FACILITY	1			STREET ADDRESS, C	ITY, STATE, ZI		-	
	HONY PARK HOME				2237 COMMONWEALT				
					SAINT PAUL, MN 5510	8			
program, corrected provision	ort is completed by a qua to show those deficience and the date such corre number and the identific by report form).	es previously repective action was	orted on the accomplishe	CMS-2567, State d. Each deficiend	ement of Deficiencies are by should be fully identif	nd Plan of Co lied using eith	rrection, that hav er the regulation	e been or LSC	
ITE	M	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0279	Correction	ID Prefix	F0282	Correction	ID Prefix	F0312		Correction
	483.20(d), 483.20(k)(1)	_		483.20(k)(3)(ii)			483.25(a)(3)		_
Reg. #		Completed	Reg. #	400.20(R)(0)(II)	Completed	Reg. #	+00.20(u)(0)		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
ID FIEIIX			ID FIEIR		Correction	ID FIEIX			- 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 Profix		Correction	ID Brofiv		Correction	ID Profix			Correction
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	<sub>дате</sub> 12/19/2016	SIGNATURE OF SURVEYOR	6022	12/05/2016	
REVIEWED BY CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF				

ID Prefix

Reg. #

LSC

Correction

Completed

Form CMS - 2567B (09/92) EF (11/06)

ID Prefix

Reg. #

10/20/2016

LSC

ID Prefix

Reg. #

LSC

Correction

Completed

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

Correction

Completed

#### POST-CERTIFICATION REVISIT REPORT

			PU31	-CERI	ILIC	AHUN	N KEVIS		PURI			
	R / SUPPLIER / (		MULTIPLE CONS								DATE O	FREVISIT
1DENTIFIC 245063	CATION NUMBER	₹ Y1	A. Building 01 - B. Wing	- Main Buil	DING 0	1				Y2	11/9/20	16 <sub>Y3</sub>
NAME OF	FACILITY						STREET ADD	DRESS, CIT	Y, STATE, ZIF	CODE		
	IONY PARK HO	OME					2237 COMM0					
							SAINT PAUL,	MN 55108				
program, corrected provision	to show those I and the date s	deficiencie uch correc	es previously repo ctive action was a	orted on the accomplished	CMS-25 d. Each	667, Statem deficiency	nent of Deficient should be full	encies and lly identifie	Plan of Cor d using eithe	ent Amendments rection, that have er the regulation of of each requirem	r LSC	
ITE	М		DATE	ITEM			D	ATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix			Correction	ID Prefix			Cor	rection	ID Prefix			Correction
Reg. #	NFPA 101		Completed	Reg. #	NFPA 1	01	Cor	npleted	Reg. #	NFPA 101		Completed
LSC	K0018		11/01/2016	LSC	K0029		11/0	1/2016	LSC	K0147		11/01/2016
ID Prefix			Correction	ID Prefix			Cor	rection	ID Prefix			Correction
Reg. #			Completed	Reg. #			Cor	npleted	Reg. #			Completed
LSC			_	LSC					LSC			
ID Prefix			Correction	ID Prefix			Cor	rection	ID Prefix			Correction
Reg.#			Completed	Reg. #			Cor	npleted	Reg. #			Completed
LSC			_	LSC					LSC			
ID Prefix			Correction	ID Prefix			Cor	rection	ID Prefix			Correction
Reg. #			Completed	Reg. #			Cor	npleted	Reg. #			Completed
LSC			_	LSC					LSC			
ID Prefix			Correction	ID Prefix			Cor	rection	ID Prefix			Correction
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LSC			_	LSC					LSC			
REVIEWE STATE AG		REVIEW (INITIAL	ED BY S) TL/KJ	DATE 12/19/	2016	SIGNATUR	E OF SURVE	or 370	08		11/C	9/2016
REVIEWE CMS RO	D BY	REVIEW (INITIAL		DATE		TITLE					DATE	

10/19/2016

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: G1TQ

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AC	GENCY	F	acility ID: 00997
MEDICARE/MEDICAID PROVIDE     (L1) 245063     2.STATE VENDOR OR MEDICAID N     (L2) 491343400		3. NAME AND AD (L3) ST ANTHON (L4) 2237 COMM (L5) SAINT PAUL	NY PARK HOME IONWEALTH AV		(L6) 55108		4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C (L9)	WNERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY 05 HHA	Y 09 ESRD	02 (L7)	) 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other mplaint
6. DATE OF SURVEY 10 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 0the	/20/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds  14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SN 84 (L37) (L38)	F 19 SNF (L39)	A. In Complia  Program Re Compliance 1. A  X B. Not in Com Requirements  ICF  (L42)	quirements Based On: Acceptable POC Appliance with Program and/or Applied Waiv IID (L43)		2. Tec 3. 24 H 4. 7-D	hnical Personnel Hour RN ay RN (Rural SNF) Safety Code B* MEETS	Following Requirements:  6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room  (L12)  (L15)	tor
<ul><li>16. STATE SURVEY AGENCY REMA</li><li>17. SURVEYOR SIGNATURE</li></ul>	RKS (IF APPLICABLE S	HOW LTC CANCELI  Date:	LATION DATE):		18. STATE SUR	VEY AGENCY API	PROVAL	Date:
Cynthia Wentkie	wicz, HFE NE	E II	11/10/2016	(L19)	Kate Jol	nnsTon, Pr	ogram Specialis	11/22/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBIL	Participate		MPLIANCE WITH C HTS ACT:	IVIL	2.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	1513)
22. ORIGINAL DATE  OF PARTICIPATION  01/04/1967  (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)		26. TERMINA  VOLUNTARY  01-Merger, Closs 02-Dissatisfactio	00		ARY  eet Health/Safety  et Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI  A. Suspension of  B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involu 04-Other Reason	ntary Termination for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C		(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (	OF APPROVAL DAT	(L33)		/23/2016 Co. ATION APPRO	VAL	



#### 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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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.

St Anthony Park Home October 31, 2016 Page 4

#### 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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.

St Anthony Park Home October 31, 2016 Page 6

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

PRINTED: 11/10/2016 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245063	B. WING		10	/20/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electron be used as verifical Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.  acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with	F 0	00			
F 279 SS=D	completed and four 483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plate The facility must deplan for each reside objectives and time medical, nursing, a needs that are identification assessment.  The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any significant to the second of t	CARE PLANS the results of the assessment and revise the resident's	F 2	79		11/18/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.

TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245063	B. WING		10/2	20/2016	
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 279	§483.10, including under §483.10(b)(4)  This REQUIREMED by: Based on observareview, the facility from	the right to refuse treatment the right to refuse treatment the.  NT is not met as evidenced tion, interview, and document failed to develop a replan for 1 of 1 resident (R13) y incontinence.  Inimum Data Set (MDS), dated R13 was occasionally an 7 documented episodes of requarterly MDS, dated R13 was frequently incontinent mented episodes of t least one episode of the plan, initiated 6/20/16, ot have a bladder incontinence	F 279	,	rinary blan eets briate eviewed inence		
	R13's orders, curre	ent as of 10/20/16, revealed no to urinary incontinence.					
	(NA)-C was observed incontinence brief a	33 a.m. nursing assistant, red assisting R13 to pull and pants down and sit on the er incontinence brief was wet.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245063	B. WING		10/	20/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 279	care. After assisting reported R13's incorand she assisted w NA-C reported R13 she needed to use  On 10/19/16, at 1:3 (RN)-B and (RN)-C comprehensive car for R13. RN-C and (nursing assistant) explained it was a cassistants, not a coand RN-C confirme indicated R13 did not wear an incort o communicate the the daily assignment shrugged her shoul reported the daily as	I R13 with providing perineal g R13 with toileting, NA-C ontinence brief was wet today ith providing perineal care.  was able to inform staff when	F 2	79			
F 282 SS=D	undated, directed s resident's program, will be implemented toileting program w care sheets and res 483.20(k)(3)(ii) SER PERSONS/PER CA	RVICES BY QUALIFIED	F 2	82		11/18/16	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245063	B. WING		10/	20/2016	
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 282	Continued From pa	age 3	F 282				
	by: Based on observar review, the facility frelated to activities residents (R54) rev Findings include: On 10/19/16, at 9:4 (NA)-A was noted to room to her bedroof transfer belt around you give me a huggethen assisted R54 to roll down and remove to the cleaned R54's other staff was presmoaned quietly who and assisted with book on 10/19/16, at 100 needed assistance transfers and toileti was doing. R54's NAR (nursing dated 10/19/16, directly Assist" and "Bed Month of the R54's care plan, lass taff: "The resident performance deficit Alzheimer's disease resident requires plans as the re	28 a.m. nursing assistant o wheel R54 from the dining am, near her bed. NA-A put at R54's waist and said "can are, can you hold onto me?", to a standing position and bed and to lay down. NA-A then onto her side to pull her pants her incontinence brief. NA-A bottom with toilet paper. No sent to assist R54. R54 alle being transferred, turned arief changes and peri-care.  256 a.m. NA-A reported R54 from 1-2 staff for bed mobility, ng, depending on how she		St. Anthony Park Home will ensicare plans are accurate regardin transferring and that nursing ass follow the care plan. Resident 5-plan has been corrected and the care sheet reflects that accurate information regarding transfers. Each resident's care plan will be to ensure the transfer and bed minformation is accurate.	g istants 1's care NAR reviewed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245063	B. WING		10/20/2016	
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 282 F 312 SS=D	Use: The resident r 2 staff for dignity to resident requires pl with pivot transfers 10/20/16, further di during transfers and striking arms, legs or hard surface."  On 10/19/2016, at R54 required assistance of 2 mobility per R54's on nursing assistants s NAR daily assignm 483.25(a)(3) ADL CDEPENDENT RES  A resident who is undaily living receives	equires physical assistance by ileting." and "Transfer: The hysical assistance of 1-2 staff" The care plan, last revised rected staff "Use caution d bed mobility to prevent and hands against any sharp al:30 p.m., RN-C confirmed cance of 1-2 staff for transfers a staff for toileting and bed care plan. RN-C reported should follow directions on the ent sheet.	F 282		11/23/16	
	by: Based on observatoreview, the facility for care and services rolliving (ADLs) for 1 of for ADLs.  Findings include: R54's most recent dated 8/28/16, reveal	NT is not met as evidenced ion, interview and document ailed to provide the necessary elated to activities of daily of 3 residents (R54) reviewed  Minimum Data Set (MDS), aled R54 had both long and problems as well as no recall		Nursing staff will provide the necesservices, as directed by the care plantegarding transferring and bed mobined the NAR care sheet reflects the accurate the NAR care sheet reflects the accurate plan information regarding transferring and bed mobility. Each residents care plan will be revand updated if need be to reflect accurate the needed for bed mobility transferring.	an, bility. e and curate viewed ccurate	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245063	B. WING			10/2	20/2016	
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE  237 COMMONWEALTH AVENUE  6AINT PAUL, MN 55108	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 312	ability and severely The MDS further in extensive assistant mobility, transfers at On 10/19/16, at 9:4 (NA)-A was noted to room to her bedroot transfer belt around you give me a hug? then assisted R54 to roll down and remove her to her be assisted R54 to roll down and remove her then cleaned R54's other staff was presmoaned quietly white and assisted with bound of the companient of the c	impaired decision making. dicated R54 required be from two staff for bed and toileting.  8 a.m. nursing assistant of wheel R54 from the dining m, near her bed. NA-A put a R54's waist and said "can are can you hold onto me?", so a standing position and sed and to lay down. NA-A then onto her side to pull her pants her incontinence brief. NA-A bottom with toilet paper. No sent to assist R54. R54 le being transferred, turned arief changes and peri-care.  56 a.m. NA-A reported R54 from 1-2 staff for bed mobility, ng, depending on how she sessment, dated 9/2/16, is no longer ambulatory and the with all ADL's (activities of es physical staff assist with all ansfers." and "Requires aff assistance for all toileting care, brief change, and the date of the session of the	F3	312	Nursing assistants will be in service the requirement to provide care as directed by the care plan.  ADL's involving transfers will be mintermittently on a daily basis.  The DON, ADON and QA nurses we ensure the above mentioned monit completed.	onitored vill		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245063	B. WING		10/	20/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 315 SS=D	performance deficit Alzheimer's disease resident requires ph turn, reposition and Use: The resident r 2 staff for dignity to resident requires ph with pivot transfers. 10/20/16, further diduring transfers and striking arms, legs or hard surface."  On 10/19/2016 at 1 required assistance of 2 staf RN-C reported nursidirections on the Na a nursing assistant different level of cal assignment sheet, inform the nurse on then re-evaluate an physical therapy as 483.25(d) NO CATH RESTORE BLADD  Based on the reside assessment, the faresident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and service.	a r/t (related to) terminal e." and "Bed Mobility: The hysical assistance by 2 staff to boost up in bed." and "Toilet equires physical assistance by ileting." and "Transfer: The hysical assistance of 1-2 staff." The care plan, last revised rected staff "Use caution d bed mobility to prevent and hands against any sharp.  30 p.m., RN-C confirmed R54 of 1-2 staff for transfers and if for toileting and bed mobility. Sing assistants should follow AR daily assignment sheet. If noticed residents needed a re than on the NAR daily the nursing assistant should a the unit. The nurse should a consult with occupational or needed.  HETER, PREVENT UTI, ER  ent's comprehensive cility must ensure that a sign to catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder	F3			11/23/16	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURV COMPLETED 10/20/20	
		245063	B. WING		10/	20/2016
	PROVIDER OR SUPPLIER	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 315	by: Based on observareview, the facility freviewed for urinary provided with the sthe highest practical. Findings include: R13's admission M 6/12/16, revealed Fincontinent (less the incontinent (less the incontinence) and revealed R13 was sthan 7 documented at least one episod required extensive. R13's urinary care 6/15/16, revealed "episodes of incontinence of clothing, transfer incontinence episod and was higher did receive physical of clothing, transfer incontinence episod at all times."  Review of R13's carevealed R13 did not care plan initiated to Review of R13's Nassignment sheet, revealed the follow Incontinent Productions.	NT is not met as evidenced tion, interview, and document failed to ensure 1 of 1 resident y incontinence (R13) was ervices necessary to achieve able level of bladder function.  Inimum Data Set (MDS), dated R13 was occasionally an 7 documented episodes of required limited assistance for larterly MDS, dated 9/10/16, frequently incontinent (more depisodes of incontinence, but le of continent voiding) and assistance for toilet use.  area assessment, dated Resident had 2 documented nence during observation hly involved in toileting task but all assistance for management res to toilet, and peri-care with des. Resident wears a pull up are plan, initiated 6/20/16, ot have a bladder incontinence until 10/19/16.  AR (nursing assistant) daily dated October 19, 2016 ing: "Incontinence: No;	F 315	St. Anthony Park Home has impleted appropriate care plan regarding urinary incontinence for residents will reviewed and updated, if necessative correct urinary incontinence particles and the correct urinary incontinence particles and the correct urinary incontinence particles are plan.  Nursing assistants will be in servitive requirement to provide care addirected by the care plan.	ng 13. The be ary, with lan. eflect the	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
		245063	B. WING	<del></del>	1,	0/20/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CEACH CORRECTIVE ACTION SHOUTH CORREST TO THE APPORT OF THE APPORT	OULD BE	(X5) COMPLETION DATE
F 315	on 10/19/16, at 9:3 (NA)-C was observed incontinence brief at toilet. R13 noted he NA-C then assisted care. After assisting reported R13's incommand and she assisted with NA-C reported R13 she needed to use of the NA-C reported R13 she needed to use of the NA-C reported R13 she needed to use of the NA-C reported R13 she needed to use of the NA-C reported R13 she needed to use of the NA-C reported R13 she needed to use of the NA-C reported R13 she needed to use of the NA-C reported R13 she needed to use of the NA-C reported R13 she needed to use of the NA-C reported R13 she needed to articulate bladder function. R1 was no comprehensincontinence for R1 the NAR (nursing a sheet and explained nursing assistants, plan. RN-B and RN assignment sheet in experience incontinincontinence brief at the need to void. When the NA-C reported R13 sheet and explained nursing assistants, plan. RN-B and RN assignment sheet where shoulders. RN-L assignment sheets past copies were not the NA-C reported R13 sheet and explained nursing assistants, plan. RN-B and RN assignment sheet where shoulders. RN-L assignment sheets past copies were not the NA-C reported R13 sheet and explained nursing assistants, plan. RN-B and RN assignment sheet where shoulders. RN-L assignment sheets past copies were not the NA-C reported R13 sheet and explained nursing assistants.	nt as of 10/20/16, revealed no to urinary incontinence.  3 a.m. nursing assistant, ed assisting R13 to pull and pants down and sit on the or incontinence brief was wet. R13 with providing perineal gR13 with toileting, NA-C antinence brief was wet today ith providing perineal care.  was able to inform staff when the toilet.  2 p.m. registered nurses confirmed R13 went from nent on the admission MDS, frequently incontinent for the S. RN-B and RN-C were the reason R13 declined in N-B and RN-C reported there sive care plan for urinary 3. RN-C and RN-B reviewed ssistant) daily assignment dit was a care guide for the not a comprehensive care -C confirmed the daily indicated R13 did not ence, did not wear an and was able to communicate hen asked if the daily was accurate, RN-C shrugged and RN-C reported the daily were frequently changed and	F3	15		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245063	B. WING		10	/20/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 315 F 334 SS=E	resident's program, will be implemented toileting program w care sheets and res	an appropriate plan of care d. Resident's individual ill be on the nursing assistant's	F3			11/30/16
SS=E	The facility must de that ensure that (i) Before offering the each resident, or the representative recebenefits and potent immunization; (ii) Each resident is immunization Octoberation	ives education regarding the ial side effects of the  offered an influenza oer 1 through March 31 eximmunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical refusal.				

			` '				
		245063	B. WING		<del></del>	CTION (X OULD BE COMPL	
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	the benefits and poimmunization; (ii) Each resident is immunization, unless medically contraind already been immu (iii) The resident or representative has immunization; and (iv) The resident's redocumentation that following:  (A) That the residerepresentative was the benefits and popneumococcal immunication or (v) As an alternative and practitioner recogneumococcal immunization, unless immunization, unles	e receives education regarding tential side effects of the  offered a pneumococcal as the immunization is icated or the resident has nized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of funization; and ent either received the funization or did not receive immunization due to medical refusal.  e, based on an assessment ommendation, a second funization may be given after 5 first pneumococcal as medically contraindicated or resident's legal representative	F3	334			
	by: Based on interview facility failed to ens were offered to 5 of R43, R6) whose im	NT is not met as evidenced and document review, the ure pneumococcal vaccines 5 residents (R20, R40, R36, munization records were n, the facility failed to develop			St. Anthony Park Home has developed accurate guidelines for Pneumococ Conjugate Vaccine (PCV)-13 as developed by the CDC. Resident R20, R40, R36, R43 and	ccal	

245063  B. WING	0/20/2016  (X5)  COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2237 COMMONWEALTH AVENUE	(X5) COMPLETION
SAINT PAUL, MN 55108	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
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:  F 20 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 and 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	245063	B. WING _		10/2	20/2016
NAME OF PROVIDER OR SUPPLIER  ST ANTHONY PARK HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
know you are asking but we did not update.  During interview with (DON) on 10/20/16, a stated "we are work in an actual policy approbut at this point we are directive and recommare looking into, ADC and she put this policy reviewed. We are plate pneumococcal vaccing.  Policy: Undated policy Pneumococcal immunities the immunizate contraindicated or the immunized the restriction resident will receive the pneumococcal immunities and pote pneumococcal immunities and the pneumococcal immunities and pote pneumococcal immunities and the pneumococcal immunities and pote pneumococcal immuniti	me about the Pneumovax e our system yet."  the Director of nursing at 12:07 p.m. The DON in progress, we do not have oved by the facility in place, re going with the physician nendation, it is something we DN got the training last week by in place but needs to be anning to incorporate all the nation as recommended."  by titled, "Policy for unization" indicated "Each pneumococcal immunization, tion is medically e resident has already been sident or resident's legal provided education regarding ential side effects of unization. Vaccine received either PCV 13 (Prevnar 13) ovax 23) Resident either pococcal immunization or did mococcal immunization due cation or refusal."	F 3	34		11/10/16

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245063	B. WING		10/2	20/2016
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	age 13	F 371			
	by: Based on observareview, the facility fice machines were sanitary manner. Tresidents who were related, to the defice.  On 10/17/16, at 12 observed to be flying the counter. There crumbs and dust of pan was noted to be drying counter. The above the clean disnoted to have blue racks.  On 10/20/16, at 10 (DS) confirmed a horown crumbs and DS sprayed the top with a rag, which can on the clean dish so buildup of crumbs a confirmed the disported for serving drying racks had blue metal. The first flock have orange buildured.	NT is not met as evidenced tion, interview and document ailed to ensure the kitchen and maintained in a clean and his had the potential to affect eserved food and or ice tiencies noted below.  30 p.m. fruit flies were a garound near sandwiches on was a heavy buildup of an the dishwasher. A disposable to evashed and put on the exclean dishes drying counter, shes from the dishwasher, was plastic peeling off the metal to a.m. the dietary supervisor eavy buildup of orange and dust on top of the dishwasher. To of the dishwasher and wiped aused dust and crumbs to fall ide. DS was not sure what the eand dust were from. DS osable pans were washed and hot food. DS confirmed the ue plastic peeling from the or ice machine was noted to up on the upper side of the lof ice. On the 2nd floor, the		St. Anthony Park Home does, and manage food under sanitary conditi Pest services have made an additional stops and the service stop for the kitchen and will continue to make additional stops anecessary. Although the alleged "filles" were not fruit flies, according pest service, we have purchased a specific container for bananas and fruits that come in boxes. The top of dishwasher has been cleaned and on a schedule for daily cleaning. To drying racks have been replaced artime use aluminum pans will be disafter one use. Dietary staff have be serviced on the schedule for cleanit top of the dishwasher and the one tuse of aluminum foil pans. The manufacturer's recommendations for cleaning the 2nd floor ice machine been initiated. The 1st floor ice machine been initiated. The 1st floor ice machine been cleaned. The dietary manager will monitor the cleanliness of the dishwasher and the kitchen for any pests on a daily bast. The Maintenance director will perfor servicing and cleaning of the 1st and floor ice machines as per the manufactures recommendations.	ions. conal as ruit to our other of the is now he nd one carded een in ng the time for have achine he the sis. orm the	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG		E SURVEY IPLETED
		245063	B. WING _		10/	20/2016
	PROVIDER OR SUPPLIER HONY PARK HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 371	and red in the ice a tray under the chute monitor the cleaning and water machines reported housekeep the ice and water manager (MM) reported to 1st floor ice bin not have a cleaning ice and water mach white, yellow, orang and water chutes at able to provide mar for cleaning the 2nd.  The Ice Machine ar undated, directed sidaily. 2. Rinse and dispense are NOT mea 483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Pr safe, sanitary and othelp prevent the of disease and infection Control The facility must es Program under whice (1) Investigates, coin the facility;	sines had white, yellow, orange and water chutes and on the es. DS reported she did not g and maintenance of the ice s. The housekeeping manager pers just wipe the outside of machines. The maintenance ported he cleaned the inside of about every 6 months but did a procedure for the 2nd floor sine. MM confirmed buildup of ge and red substance in the ice and tray below. MM was not aufacturer recommendations of floor ice and water machine.  In Refrigerators Policy, taff "1. Wash outside surfaces dry."  I CONTROL, PREVENT  I CONTROL, PREVENT  I tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.  I Program tablish an Infection Control	F 37			11/23/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245063	B. WING		10/20/2016	
	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLÉTION	
F 441	(3) Maintains a recoactions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each direct washing is incorressional practic (c) Linens Personnel must hat transport linens so	o an individual resident; and ord of incidents and corrective affections.  ead of Infection cion Control Program esident needs isolation to of infection, the facility must asse or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 441			
	by: Based on observa review, the facility f handwashing durin 4 (R54, R59) reside cares. Findings include: On 10/19/16, at 9:4 (NA)-B removed Ri and applied a new	NT is not met as evidenced tion, interview and document ailed to ensure proper g cares was completed for 2 of ents reviewed for personal  8 a.m. nursing assistant 54's soiled incontinence brief brief with gloved hands. NA-B tinuing to produce a bowel		St. Anthony Park Home will ensur proper handwashing techniques ar use will be used during cares. All nursing assistants will receive to on our glove use policy, as well as handwashing policy. A handwashi return demonstration will be require nursing assistants.  Glove use and handwashing will be monitored intermittently on a daily The DON, ADON and QA nurses we ensure the above mentioned monit	raining our ng ed of all basis. vill	

		TE SURVEY MPLETED				
		245063	B. WING		10	/20/2016
_	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2237 COMMONWEALTH AVEN SAINT PAUL, MN 55108	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O  (EACH CORRECTIVE AG  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 441	R54 again shortly. soiled incontinence into the bathroom a 10 seconds to R54 gloves. NA-B then her call light and R: NA-B then opened nearby room to waremoved her glove until after she left the On 10/18/16, at 9:4 observed assisting mechanical standir sitting upright while NA-A and NA-D the up with use of the removing pants and pants down and he washed her hands them on her pants room. NA-A remain R59. R59 had a bo 10:12 a.m. NA-D renear the toilet as N applied a brief and NA-A removed her sanitize hands. NA the toilet to the bed NA-A and NA-D the NA-D straightened placed a wedge un floor mat into place removed her glove five seconds, dried room. NA-A called	would come back and change NA-B then gathered the bag of a brief and toilet paper, went and came right back out within. NA-B was not wearing put the blanket on R54, moved 54's hands near the call light. the door and went into the sh hands. NA-B confirmed she as but did not wash her hands	F 4	completed.		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245063	B. WING		ļ	10/:	20/2016
	PROVIDER OR SUPPLIER HONY PARK HOME			STREET ADDRESS, CITY, STATE, ZI 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 441	of nursing (RN)-E renursing assistants to according to how the and procedure and to use as appropriate. The Handwashing procedure and to use as appropriate. The Handwashing procedure and the seconds generating including under fing 5. Pat dry thorough faucet off using a prom dirty faucet. 7. waste basket. 8. Has and after providing between residents, and entering a cleate. Hand hygiener the use of antiseptic sure all organic max (i.e. visible dirt) 2. A hand sanitizer to the waterless hand san together covering a fingers. Rub until has	47 a.m. the assistant director eported she would expect o wash or sanitize hands ley were trained per the policy hand sanitizer was available te.  coolicy, updated 3/19/12, hands with running water. 2. roughly disperse over hands. In the first on all surfaces ernails. 4. Rinse thoroughly. It with paper towels. 6. Turn laper towel to protect hands. Dispose of paper towel in lands are to be washed before personal cares for a resident, before leaving a dirty area in area, after removing gloves, may also be performed with the hand rub as follows: 1. Make the is removed from hands apply a dime sized amount of the palm of one hand or use a itizer wipe. 3. Rub hands and and sanitizer is absorbed. 4. cap and water after every	F 4	41			

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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	1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION 02 - ANOKA CARE & REHAB CENTER	(X3) DATE COMP	SURVEY
ANOKA REHABILITATION AND LIVING CENTER  3000 4TH AVENUE ANOKA, MM 55303 ANOKA, MM 55303  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICENCY MUST BE PRECEDED BY FULL RESULATIONY OR LSO IDENTIFYING INFORMATION)  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			245205	B. WING			10/	19/2016
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  K 000  INITIAL COMMENTS  K 000  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			/ING CENTER		;	3000 4TH AVENUE		
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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
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facility is licensed for 120 beds and 109 were		A Life Safety Code Somminesota Department Fire Marshal Division the time of this survey Living Center was for compliance with the rin Medicare/Medicaid 483.70(a). Life Safety edition of National Fire (NFPA) Standard 101 Chapter 18 New Health Anoka Care-Rehability constructed in 2012 at two story building with construction type is decently of the complex by 2 hours the complex by 2 hours facility has a complete system, with smoke despaces open to the conduction to the conduction of the conducti	nt of Public Safety, State , on October 19, 2016. At y Anoka Rehabilitation & and in substantial equirements for participation at 42 CFR, Subpart y from Fire, and the 200 re Protection Association , Life Safety Code (LSC) Ith Care.  ration Center was and opened in 2013. It is a n a basement. The etermined to be Type II separated from the rest of ar fire rated construction.  prinkler protected. The e automatic sprinkler letection in the corridors and pridor, that is monitored for ment notification. All single station smoke					
occupied at the time of inspection.  The requirement at 42 CFR Subpart 483.70(a) is MET.  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATI	LABODATODY	occupied at the time of the requirement at 42 MET.	of inspection. 2 CFR Subpart 483.70(a) is			TITI E		(X6) DATE

11/12/2016 **Electronically Signed** 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.

PRINTED: 11/04/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245063 B: WING 10/19/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2237 COMMONWEALTH AVENUE ST ANTHONY PARK HOME SAINT PAUL, MN 55108 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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: (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

11/01/2016

**Electronically Signed** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245063			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		B. WING			10/19/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  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 PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH FOR CROSS-REFERENCED TO THE APPROPRIED TO THE APPROP		) BE	(X5) COMPLETION DATE	
K 000	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		K 000				
	basement, and war (111) construction. were constructed of separated with a 2 original building an The building is divident level except thour fire barriers.  An automatic sprint throughout the build alarm system with down the corridors smoke detection in all the sleeping r	hich was 1-story, with a sign determined to be Type II In 1999 a 2nd and 3rd floor over the 1960 addition that are hour fire barrier from the 1900 d are Type II(111) construction, ded into 11 smoke zones (3 he basement) by at least 1 kler system is installed ding. The building has a fire automatic smoke detectors with additional automatic all common use spaces and cooms of the 1999 additions. ic fire detection is provided in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
245063			B. WING		10	10/19/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2237 COMMONWEALTH AVENUE  SAINT PAUL, MN 55108				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
K 018 SS=E	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: 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		ΚO			11/1/16		
	pushed or pulled a provided with a medoor closed. Dutch permitted. Door framade of steel or owith 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Doors protecting or required enclosure hazardous areas as those construct core wood, or capa 20 minutes. Cleara	release when the door is are permitted. Doors shall be eans suitable for keeping the in doors meeting 19.3.6.3.6 are ames shall be labeled and ther materials in compliance ler latches are prohibited by in all health care facilities.  is not met as evidenced by: corridor openings in other than as of vertical openings, exits, or shall be substantial doors, such add of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door is not exceeding 1 inch. Doors		The door to room 303 and the west elevator doors have been to maintenance director will doors to ensure they latch an properly.	en repaired. I monitor			

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

PRINTED: 11/04/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION G <b>01 - Main Building 01</b>	COMPLETED		
		245063	B. WING_		10	/19/2016
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 018	required to resist to no impediment to open devices that pushed or pulled a provided with a modor closed. Duto permitted. Door from the second	smoke compartments are only the passage of smoke. There is the closing of the doors. Hold release when the door is are permitted. Doors shall be eans suitable for keeping the h doors meeting 19.3.6.3.6 are ames shall be labeled and other materials in compliance aller latches are prohibited by all health care facilities.  It ween 09:00 AM and 01:00 PM and on observation and interview findings iclude:  303 has a door that does not tested.	K 01	8		
K 029 SS=D	the residents, staff compartment.  This deficient practic prac	ctice could affect the safety of all if and vistors within the smoke ctice was confirmed by the nee Director at the time of AFETY CODE STANDARD of construction (with o hour or an approved automatic fire tem in accordance with 8.4.1 rotects hazardous areas. When commatic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or	K 02	29		11/1/16

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

PRINTED: 11/04/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245063	B. WING			)/19/2016
	PROVIDER OR SUPPLIER	,		22	REET ADDRESS, CITY, STATE, ZIP CODE  37 COMMONWEALTH AVENUE  AINT PAUL, MN 55108	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	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.		K 029		A magnetic latch was placed on the door in the 2nd floor east utility room in order tachieve compliance.	
K 147 SS=D	the residents staff compartment.  This deficient pract Facility Maintenand discovery.  NFPA 101 LIFE SA  Electrical wiring an accordance with N (NFPA 99) 18.9.1, This STANDARD Electrical wiring an	is not met as evidenced by: nd equipment shall be in ational Electrical Code. 9-1.2	K	147	An outlet cover was placed on the outlet above the 2nd floor stairwell door and or of the refrigerators was plugged directly	

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

PRINTED: 11/04/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION NG <b>01 - Main Building 01</b>		COMPLETED	
		245063	B. WING _		10/1	9/2016
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP CODE  2237 COMMONWEALTH AVENUE  SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
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## 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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

St Anthony Park Home October 31, 2016 Page 2

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

PRINTED: 11/10/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00997 10/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE ST ANTHONY PARK HOME SAINT PAUL, MN 55108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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

**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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/in">http://www.health.state.mn.us/divs/fpc/profinfo/in</a> fobul.htm> The State licensing orders are delineated on the attached Minnesota

the Department within 15 days of receipt of a notice of assessment for non-compliance.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/10/16

(X6) DATE

TITLE

**Electronically Signed** 

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

(X3) DATE SURVEY COMPLETED

00997 B. WING \_\_\_\_\_\_ 10/20/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER STREET A		STREET ADD	ADDRESS, CITY, STATE, ZIP CODE				
ST ANT	HONY PARK HOME		IMONWEAL <sup>*</sup> UL, MN 551				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 000	Continued From page 1  Department of Health orders being submyou electronically. Although no plan of c is necessary for State Statutes/Rules, pleenter the word "corrected" in the box avatext. You must then indicate in the electrostate licensure process, under the headicompletion date, the date your orders with corrected prior to electronically submitting Minnesota Department of Health.  On October 17, 18, 19 and 20th, surveyor Department's staff, visited the above prothe following correction orders are issued Please indicate in your electronic plan of correction that you have reviewed these and identify the date when they will be concorrected and found not to be substanticated and found not to be substantic	orrection ease allable for onic ing III be g to the orders, ompleted. was ated. menting sing in es for e far left ate the olumn the des the e statute t as indings and of THE	2 000				

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Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST ANTH	IONY PARK HOME		IMONWEAL UL, MN 551	TH AVENUE 08			
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2 000	Continued From pa	ge 2	2 000				
	APPLIES TO FEDE THIS WILL APPEA	ERAL DEFICIENCIES ONLY. R ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			11/18/16	
	comprehensive plan objectives and time long- and short-term and mental and psy identified in the com assessment. The comust include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are aprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).					
	by: Based on observati review, the facility fa	e plan for 1 of 1 resident (R13)		corrected			
	Findings include:						
	6/12/16, revealed R incontinent (less that incontinence). R13' 9/10/16, revealed R (more than 7 docum	inimum Data Set (MDS), dated 113 was occasionally an 7 documented episodes of s quarterly MDS, dated 113 was frequently incontinent nented episodes of least one episode of					

Minnesota Department of Health

STATE FORM 6899 G1TQ11 If continuation sheet 3 of 21

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00997	B. WING		10/2	0/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST ANTH	ONY PARK HOME		IMONWEAL UL, MN 551	TH AVENUE 08		
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2 560	Continued From pa	ge 3	2 560			
	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.					
	assignment sheet, or revealed the following Incontinent Product	AR (nursing assistant) daily dated October 19, 2016 ng: "Incontinence: No; ts:[blank]; Able to eed to void-Uses call light."				
	R13's orders, current as of 10/20/16, revealed no instructions related to urinary incontinence.					
	(NA)-C was observed incontinence brief at toilet. R13 noted he NA-C then assisted care. After assisting reported R13's income and she assisted w	3 a.m. nursing assistant, ed assisting R13 to pull and pants down and sit on the er incontinence brief was wet. I R13 with providing perineal g R13 with toileting, NA-C ontinence brief was wet today ith providing perineal care. I was able to inform staff when the toilet.				
	(RN)-B and (RN)-C comprehensive car for R13. RN-C and (nursing assistant) explained it was a cassistants, not a coand RN-C confirme indicated R13 did n did not wear an incoto communicate the daily assignmer shrugged her shoul reported the daily a	2 p.m. registered nurses confirmed there was no e plan for urinary incontinence RN-B reviewed the NAR daily assignment sheet and care guide for the nursing imprehensive care plan. RN-B and the daily assignment sheet of experience incontinence, ontinence brief and was able to need to void. When asked if it sheet was accurate, RN-C ders. RN-B and RN-C ssignment sheets were and past copies were not				

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Minnesota Department of Health STATE FORM

G1TQ11 If continuation sheet 4 of 21

PRINTED: 11/10/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00997 10/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE ST ANTHONY PARK HOME SAINT PAUL, MN 55108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 5 6 0 Continued From page 4 2 560 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

Minnesota Department of Health STATE FORM

incontinence, but at least one episode of

care plan initiated until 10/19/16.

Review of R13's care plan, initiated 6/20/16, revealed R13 did not have a bladder incontinence

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."

continent voiding).

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00997	B. WING		10/2	20/2016
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ST ANTH	ST ANTHONY PARK HOME SAINT P			TH AVENUE 08		
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2 560	instructions related On 10/19/16, at 9:3 (NA)-C was observed incontinence brief at toilet. R13 noted he NA-C then assisted care. After assisting reported R13's incompany and she assisted with NA-C reported R13's he needed to use. On 10/19/16, at 1:3 (RN)-B and (RN)-C comprehensive carrier R13. RN-C and (nursing assistant) explained it was a cassistants, not a company and and and was a cassistant of the daily assignment of the daily assignment shrugged her should reported the daily a frequently changed retained.  The Bowel and Blacundated, directed some sident's program, will be implemented toileting program with care sheets and reserved.	nt as of 10/20/16, revealed no to urinary incontinence.  3 a.m. nursing assistant, ed assisting R13 to pull and pants down and sit on the r incontinence brief was wet.  R13 with providing perineal gR13 with toileting, NA-C antinence brief was wet today ith providing perineal care.  was able to inform staff when the toilet.  2 p.m. registered nurses confirmed there was no e plan for urinary incontinence RN-B reviewed the NAR daily assignment sheet and care guide for the nursing mprehensive care plan. RN-B d the daily assignment sheet of experience incontinence, ontinence brief and was able eneed to void. When asked if at sheet was accurate, RN-C ders. RN-B and RN-C ssignment sheets were and past copies were not dider Assessment Policy, taff: "Upon identifying an appropriate plan of care I. Resident's individual II be on the nursing assistant's	2 560			

Minnesota Department of Health STATE FORM

If continuation sheet 6 of 21 G1TQ11

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00997	B. WING		10/2	0/2016
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ST ANTH	IONY PARK HOME		IMONWEAL <sup>.</sup> UL, MN 551			
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2 560	The director of nurs staff to develop a c identification of all imonitoring program to assure ongoing a interventions in result.  TIME PERIOD FOR (21) days.	sing or designee could direct are plan to include dentified care needs. An could be established in order and effective care plan ponse to resident care needs.  R CORRECTION: Twenty one	2 560			
2 303	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		2 565	corrected		11/18/16
	(NA)-A was noted to room to her bedroot transfer belt around you give me a hug? then assisted R54 to pivoted her to her be assisted R54 to roll down and remove h	o wheel R54 from the dining m, near her bed. NA-A put d R54's waist and said "can?, can you hold onto me?", so a standing position and sed and to lay down. NA-A then onto her side to pull her pants her incontinence brief. NA-A bottom with toilet paper. No				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

MAME OF PROVIDER OR SUPPLIER  STANTHONY PARK HOME  SUMMARY STATEMENT OF DEFICIENCIES PREETE TAG  PREETE TAG  PRECIVE CORNECTIVO OR USCI DENTIFYING INFORMATION)  DEPROVIDERS PLAN OF CORRECTION PREETE TAG  PRECIVE CORNECTIVO OR USCI DENTIFYING INFORMATION)  PRECIVE TAG  PRECIVE TAG  PRECIVE TAG  PROVIDERS PLAN OF CORRECTION PRECIVE TAG  PRECIVE TAG  PROVIDERS PLAN OF CORRECTION PRECIVE TAG  PRECIVE TAG  PROVIDERS PLAN OF CORRECTION PRECIX PLAN OF CORRECTION PROVIDERS  PRECIX PLAN OF CORRECTION PRECIX PLAN OF CORRECTION PROVIDERS  PROVIDERS  P	-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ST ANTHONY PARK HOME  2237 COMMONWEALTH AVENUE SAINT PAUL, IMN 55108    MAI   ID   PREVIOUR ACTION SHOULD BE   DEFICIENCES   PROVIDERS PLAN OF CORRECTION				A. BUILDING.				
STANTHONY PARK HOME   SAINT PAUL, MN   55108			00997	B. WING		10/2	0/2016	
CALL   DESCRIPTION   CRACKED   CRA	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCY	ST ANTH	ONY PARK HOME						
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" and "Bed Mobility: 2 Assist" and "Bed Mobility: 1 R54's care plan, last revised 10/17/16, directed staff: "The resident has an ADL self-care performance deficit rft (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 by 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.	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE	
director of nursing (DON) or designee, could develop and implement policies and procedures	2 565	other staff was presmoaned quietly whi and assisted with bound assisted with bound assisted with bound assisted assistance transfers and toileting was doing.  R54's NAR (nursing dated 10/19/16, director of nursing assistants of 2 mobility per R54's care plan, last staff: "The resident performance deficit Alzheimer's disease resident requires play turn, reposition and Use: The resident requires play with pivot transfers. 10/20/16, further diduring transfers and striking arms, legs or hard surface."  On 10/19/2016, at R54 required assistant assistance of 2 mobility per R54's of nursing assistants stand assistants of 2 mobility per R54's of nursing assistants o	sent to assist R54. R54 le being transferred, turned rief changes and peri-care.  56 a.m. NA-A reported R54 from 1-2 staff for bed mobility, ng, depending on how she  g assistant) daily assignments, ected staff: "Transferring: 2 obility: 2 Assist."  at revised 10/17/16, directed has an ADL self-care r/t (related to) terminal e." and "Bed Mobility: The hysical assistance by 2 staff to boost up in bed." and "Toilet equires physical assistance by ileting." and "Transfer: The hysical assistance of 1-2 staff." The care plan, last revised rected staff "Use caution d bed mobility to prevent and hands against any sharp  1:30 p.m., RN-C confirmed tance of 1-2 staff for transfers estaff for toileting and bed care plan. RN-C reported should follow directions on the ent sheet.  CHOD OF CORRECTION: The (DON) or designee, could	2 565				

Minnesota Department of Health

STATE FORM 6899 G1TQ11 If continuation sheet 8 of 21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,			(X3) DATE SURVEY COMPLETED	
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		00997	B. WING		10/2	20/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	IONY PARK HOME		IMONWEAL UL, MN 551	TH AVENUE 08		
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2 565	Continued From pa	ge 8	2 565			
	staff related to follo assurance committ audits to ensure co	ovide training for all nursing wing the care plan. The quality ee could perform random mpliance.  R CORRECTION: Twenty-one				
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence		2 910			11/23/16
	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.					
	by: Based on observati review, the facility for reviewed for urinary provided with the se	ent is not met as evidenced on, interview, and document ailed to ensure 1 of 1 residents vincontinence (R13) was ervices necessary to achieve able level of bladder function.		corrected		

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

NAME OF PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	TATE, ZIP CODE	
ST ANTH	ONY PARK HOME		IMONWEALT UL, MN 5510		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED I REGULATORY OR LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 9  R13's admission Minimum Data Set (I 6/12/16, revealed R13 was occasional incontinent (less than 7 documented exincentinence) and required limited assisted to use. R13's quarterly MDS, dated revealed R13 was frequently incontined than 7 documented episodes of incontal least one episode of continent voiding required extensive assistance for toiled R13's urinary care area assessment, 6/15/16, revealed "Resident had 2 docepisodes of incontinence during obserperiod and was highly involved in toiled did receive physical assistance for many of clothing, transfers to toilet, and pering incontinence episodes. Resident wear at all times."  Review of R13's care plan, initiated 6/12/16 revealed R13 did not have a bladder in care plan initiated until 10/19/16.  Review of R13's NAR (nursing assistational assignment sheet, dated October 19, revealed the following: "Incontinence: Incontinent Products:[blank]; Able to communicate the need to void-Uses of R13's orders, current as of 10/20/16, instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistations related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistations related to urinary incontinence. R13's orders, current as of 10/20/16, instructions related to urinary incontinence. On 10/19/16, at 9:33 a.m. nursing assistations related to urinary incontinence. R13's orders, current as of 10/20/16, instructions related to urinary incontinence brief and pants down and toilet. R13 noted her incontinence brief NA-C then assisted R13 with providing reported R13's incontinence brief was and she assisted with providing perine partment of Health	episodes of sistance for 19/10/16, ent (more tinence, but ing) and et use.  dated cumented rvation sting task but anagement e-care with rs a pull up  20/16, ncontinence  ant) daily 2016  No; call light."  revealed no ence.  sistant, o pull d sit on the ef was wet. g perineal , NA-C a wet today	2 910		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00997	B. WING		10/20/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST ANTI	ONY PARK HOME		IMONWEAL <sup>-</sup> UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	NA-C reported R13 she needed to use On 10/19/16, at 1:3 (RN)-B and (RN)-C occasionally incontidated 6/12/16, and MDS, dated 9/10/16 unable to articulate bladder function. Rivas no comprehen incontinence for R1 the NAR (nursing a sheet and explained nursing assistants, plan. RN-B and RN assignment sheet in experience incontinincontinence brief at the need to void. Wassignment sheets her shoulders. RN-assignment sheets past copies were not assign to the resident's program, will be implemented to to the resident's program, will be implemented to to the resident sheets and residentification of all imonitoring program.	was able to inform staff when the toilet.  2 p.m. registered nurses confirmed R13 went from nent on the admission MDS, frequently incontinent for the B. RN-B and RN-C were the reason R13 declined in N-B and RN-C reported there sive care plan for urinary 3. RN-C and RN-B reviewed ssistant) daily assignment dit was a care guide for the not a comprehensive care -C confirmed the daily indicated R13 did not lence, did not wear an and was able to communicate then asked if the daily was accurate, RN-C shrugged B and RN-C reported the daily were frequently changed and of retained.  Idder Assessment Policy, taff: "Upon identifying an appropriate plan of care did Resident's individual ill be on the nursing assistant's sident care plan."	2 910			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' · · ·			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00997	B. WING		10/2	20/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
STANTHONY PARK HOME			IMONWEAL UL, MN 551	TH AVENUE 08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 11	2 910			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			11/23/16
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility for care and services r	ent is not met as evidenced on, interview and document ailed to provide the necessary elated to activities of daily of 3 residents (R54) reviewed		corrected		
	Findings include:					
	dated 8/28/16, reve short term memory ability and severely The MDS further in	Minimum Data Set (MDS), saled R54 had both long and problems as well as no recall impaired decision making. dicated R54 required se from two staff for bed and toileting.				
	(NA)-A was noted to room to her bedroot transfer belt around you give me a hug?	8 a.m. nursing assistant o wheel R54 from the dining m, near her bed. NA-A put IR54's waist and said "can P, can you hold onto me?", to a standing position and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
7.1.12 . 2.1.1 0.1 0	30111.2011.011	.52	A. BUILDING:		30	
		00997	B. WING		10/2	0/2016
NAME OF PROV	VIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
ST ANTHON	Y PARK HOME		IMONWEAL <sup>-</sup> UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
piv ass dow the oth modern and on need train was shown and on need train was shown as the contract of the cont	sisted R54 to roll win and remove hen cleaned R54's her staff was presponded assisted with being 10/19/16, at 10:20 eded assistance and toileting doing.  64's care area assive and mobility and tractional and mobility and mobility and tractional and mobility and tractional and mobility and	ed and to lay down. NA-A then onto her side to pull her pants her incontinence brief. NA-A bottom with toilet paper. No sent to assist R54. R54 le being transferred, turned rief changes and peri-care.  56 a.m. NA-A reported R54 from 1-2 staff for bed mobility, ng, depending on how she  sessment, dated 9/2/16, is no longer ambulatory and with all ADL's (activities of es physical staff assist with all insfers." and "Requires aff assistance for all toileting care, brief change, and ."  y assistant] daily assignments, exted staff: "Transferring: 2	2 920			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1` '		(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		00997	B. WING		10/2	0/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST ANTH	IONY PARK HOME		IMONWEAL UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 13	2 920			
	required assistance assistance of 2 staf RN-C reported nurs directions on the Na a nursing assistant different level of car assignment sheet, inform the nurse on then re-evaluate an physical therapy as SUGGESTED MET director of nursing of	:30 p.m., RN-C confirmed R54 of 1-2 staff for transfers and if for toileting and bed mobility. Sing assistants should follow AR daily assignment sheet. If noticed residents needed a re than on the NAR daily the nursing assistant should a the unit. The nurse should d consult with occupational or needed.  THOD OF CORRECTION: The could re-educate all staff to regards to specific resident				
	to audit and monito	and could develop a system r for compliance.  R CORRECTION: Twenty-one				
21015	. , ,	O Subp. 7 Dietary Staff nitary conditi	21015			11/10/16
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				
	by: Based on observati review, the facility faice machines were sanitary manner. The	ent is not met as evidenced on, interview and document ailed to ensure the kitchen and maintained in a clean and his had the potential to affect e served food and or ice,		corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		00997	B. WING		10/2	20/2016
	PROVIDER OR SUPPLIER	2237 COM	MONWEALT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	related to the defici	ge 14 encies noted below.	21015			
	observed to be flyin the counter. There crumbs and dust or pan was noted to be drying counter. The above the clean dis	30 p.m. fruit flies were g around near sandwiches on was a heavy buildup of the dishwasher. A disposable washed and put on the clean dishes drying counter, hes from the dishwasher, was plastic peeling off the metal				
	(DS) confirmed a hebrown crumbs and DS sprayed the top with a rag, which can on the clean dish si buildup of crumbs a confirmed the disporeused for serving her drying racks had blumetal. The first floo have orange buildumachine. It was full ice and water mach and red in the ice a tray under the chatter and water machine reported housekeep the ice and water manager (MM) reported to the 1st floor ice bin not have a cleaning ice and water machine reported housekeep the ice and water manager (MM) reported housekeep the ice and water manager (MM) reported housekeep the ice and water manager (MM) reported housekeep the ice and water machine reported	10 a.m. the dietary supervisor eavy buildup of orange and dust on top of the dishwasher. of the dishwasher and wiped aused dust and crumbs to fall de. DS was not sure what the and dust were from. DS easile pans were washed and not food. DS confirmed the ue plastic peeling from the rice machine was noted to p on the upper side of the of ice. On the 2nd floor, the sines had white, yellow, orange and water chutes and on the es. DS reported she did not g and maintenance of the ice s. The housekeeping manager pers just wipe the outside of about every 6 months but did a procedure for the 2nd floor line. MM confirmed buildup of ge and red substance in the ice				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00997	5 WW.6		10/2	20/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ANTH	IONY PARK HOME		IMONWEAL <sup>.</sup> UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 15	21015			
	able to provide mar	nd tray below. MM was not nufacturer recommendations If floor ice and water machine.				
		nd Refrigerators Policy, taff "1. Wash outside surfaces dry."				
	An email from the food and kitchen equipment supplier, printed 10/20/16, noted "those aluminum pans are NOT meant to be reused."					
	The administrator a and revise cleaning assure that food eq sanitary manner. Snecessary. The Cer	ETHOD FOR CORRECTION: and/or dietician could review policies and procedures to uipment is maintained in a staff could be trained as rtified Dietary Manager could ment cleanliness on a periodic				
	TIME PERIOD FOR days.	R CORRECTION: Thirty (30)				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			11/30/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on interview facility failed to ensi	and document review, the ure pneumococcal vaccines 5 residents (R20, R40, R36,		corrected		

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_\_ 00997 B. WING \_\_\_\_ 10/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

ST ANTH	IONY PARK HOME	IMONWEALT UL, MN 5510		
(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
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 epartment of Health			

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PRINTED: 11/10/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 00997 B. WING \_\_\_ 10/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE ST ANTHONY PARK HOME 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
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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00007	B. WING		10/0	00/0010
		00997	B. WING		10/2	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CT ANTI	IONIV DADIV LIONE	2237 COM	<b>MONWEALT</b>	H AVENUE		
STANIF	IONY PARK HOME	SAINT PA	UL, MN 5510	08		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG		'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
21375	Continued From pa	ge 18	21375			
	and applied a new I noted R54 was con movement so she w R54 again shortly. I soiled incontinence into the bathroom a 10 seconds to R54 gloves. NA-B then pher call light and R5 NA-B then opened nearby room to was	54's soiled incontinence brief brief with gloved hands. NA-B tinuing to produce a bowel would come back and change NA-B then gathered the bag of brief and toilet paper, went and came right back out within NA-B was not wearing but the blanket on R54, moved 54's hands near the call light. The door and went into the sh hands. NA-B confirmed she is but did not wash her hands are room.				
	observed assisting mechanical standin sitting upright while NA-A and NA-D the up with use of the move him into the bremoving pants and pants down and he washed her hands them on her pants troom. NA-A remain R59. R59 had a bot 10:12 a.m. NA-D renear the toilet as Napplied a brief and NA-A removed her sanitize hands. NA the toilet to the bed NA-A and NA-D the NA-D straightened placed a wedge uncome the standing of the standing of the sanitize hands. NA the toilet to the bed NA-A and NA-D the NA-D straightened placed a wedge uncome the standing of the sanitize hands.	2 a.m. NA-A and NA-D were R59 from his wheelchair into a g lift. NA-A assisted R59 with NA-D placed leg straps up. In assisted R59 with standing nechanical standing lift and pathroom, assisted him with a incontinence brief and pulling ped him sit on the toilet. NA-D for five seconds, then wiped to dry them. NA-D then left the ed in the room to supervise wel movement in the toilet. At turned to assist R59 stand A-A wiped R59's perineal area, pulled his pants back up. gloves but did not wash or -D and NA-A moved R59 from and to sit and rest in his bed. In removed R59's shoes. The blankets on R59's bed, der R59's legs and moved a near R59's bed. NA-D then and washed her hands for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00997	B. WING		10/2	20/2016
	PROVIDER OR SUPPLIER	2237 CO	DDRESS, CITY, S MMONWEALT NUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	room. NA-A called if the room with garbathe room with garbathe staff bathroom.  On 10/19/16, at 10: of nursing (RN)-E roursing assistants the according to how the and procedure and to use as appropriate.  The Handwashing procedure and to use as appropriate.  The Handwashing procedure and to use as appropriate.  The Handwashing procedure and the seconds generating including under fing 5. Pat dry thorough faucet off using a promodirty faucet. 7. waste basket. 8. Hard after providing between residents, and entering a cleate. Hand hygiene in the use of antiseptic sure all organic marking. Visible dirty 2. A hand sanitizer to the waterless hand sanitizer to the water	for the nurse and then exited age and washed her hands in 47 a.m. the assistant director eported she would expect o wash or sanitize hands are to were trained per the policy hand sanitizer was available te.  Dolicy, updated 3/19/12, hands with running water. 2. roughly disperse over hands. ands together for 10-15 griction on all surfaces gernails. 4. Rinse thoroughly. By with paper towels. 6. Turn aper towel to protect hands. Dispose of paper towel in ands are to be washed before personal cares for a resident, before leaving a dirty area in area, after removing gloves, may also be performed with the hand rub as follows: 1. Make ter is removed from hands apply a dime sized amount of e palm of one hand or use a litizer wipe. 3. Rub hands and sanitizer is absorbed. 4. Oap and water after every sanitizer."				
		neumococcal policies and re all required information is				

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PRINTED: 11/10/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_\_\_ B. WING \_ 00997 10/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE ST ANTHONY PARK HOME SAINT PAUL, MN 55108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21375 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.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
			P WING		
		00997	B. WING		10/20/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
ST ANTHO	ONY PARK HOME		MMONWEALTH A AUL, MN 55108	AVENUE	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart				
	corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment				
	that may result from norders provided that a	earing on any assessments con-compliance with these a written request is made to a 15 days of receipt of a for non-compliance.			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at: ate.mn.us/divs/fpc/profinfo/in e licensing orders are			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00997	B. WING	<del></del>	10/20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ST ANTHO	ONY PARK HOME		MONWEALTH A	AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 000	you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department."  On October 17, 18, 19 Department's staff, vithe following correction. Please indicate in you correction that you have and identify the date. An investigation of cocompleted and found. Minnesota Department the State Licensing Completed and found. Minnesota Department the State Licensing Completed and found. Minnesota Department the State Licensing Completed and found. The assigned to Minnesota Nursing Homes.  The assigned tag nuncolumn entitled "ID is statute/rule out of com "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following are the Suggested Mediane period for Correction Correc	orders being submitted to though no plan of correction statutes/Rules, please cted" in the box available for dicate in the electronic ass, under the heading date your orders will be ctronically submitting to the not of Health.  9 and 20th, surveyors of this sited the above provider and on orders are issued.  In electronic plan of the reviewed these orders, when they will be completed.  In and the substantiated.  In the fealth is documenting or or orders are issued.  In the fealth is documenting or or orders using numbers have been a state statutes/rules for  In the state statutes/rules for  In the state in the of Deficiencies" column Comply" portion of the column also includes the violation of the state statute  This Rule is not met as any the surveyors findings ethod of Correction and ction.  In the HEADING OF THE	2 000		
	FOURTH COLUMN V	VHICH STATES, OF CORRECTION." THIS			

Minnesota Department of Health

STATE FORM 6899 G1TQ11 If continuation sheet 2 of 21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00997	B. WING		10/20/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	10/20/2016
ST ANTHO	ONY PARK HOME		MONWEALTH	AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	THIS WILL APPEAR	AL DEFICIENCIES ONLY. ON EACH PAGE. IREMENT TO SUBMIT A ION FOR VIOLATIONS OF	2 000		
2 560	Plan of Care; Contents of comprehensive plan of objectives and timetal long- and short-term of and mental and psychidentified in the comprehensive plan of the comprehensive of the comprehensive care previewed for urinary in Findings include:  R13's admission Minim 6/12/16, revealed R13 incontinent (less than incontinence). R13's of the comprehensive care previewed for urinary in Findings include:	plan of care. The of care must list measurable bles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident imprehensive plan of care idual abuse prevention plan a Statutes, section 626.557, raph (b).  It is not met as evidenced In, interview, and document ed to develop a blan for 1 of 1 resident (R13) incontinence.  In mum Data Set (MDS), dated B was occasionally 7 documented episodes of quarterly MDS, dated B was frequently incontinent inted episodes of	2 560		

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G1TQ11 If continuation sheet 3 of 21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00997	B. WING		10	/20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	·	
CT ANTU	ONA DA DA HOME	2237 COM	MONWEALTH A	AVENUE		
STANIN	ONY PARK HOME	SAINT PA	UL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 560	Continued From page	e 3	2 560			
		plan, initiated 6/20/16, have a bladder incontinence iil 10/19/16.				
	assignment sheet, da revealed the following Incontinent Products:					
		as of 10/20/16, revealed no urinary incontinence.				
	(NA)-C was observed incontinence brief and toilet. R13 noted her in NA-C then assisted R care. After assisting F reported R13's incontant she assisted with	d pants down and sit on the incontinence brief was wet. R13 with providing perineal R13 with toileting, NA-C inence brief was wet today providing perineal care.				
	(RN)-B and (RN)-C comprehensive care programmer for R13. RN-C and RI (nursing assistant) day explained it was a care assistants, not a compand RN-C confirmed indicated R13 did not did not wear an inconto communicate the number of the daily assignment shrugged her shoulded reported the daily assignment assignment the daily assignment shrugged her shoulded reported the daily assignment assignment the daily assignment the daily assignment assignment the daily assignment assignment the daily assignment as					

Minnesota Department of Health

STATE FORM 6899 G1TQ11 If continuation sheet 4 of 21

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED
		00997	B. WING		10/20	0/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST VNTH	ONY PARK HOME	2237 COM	MONWEALTH	AVENUE		
31 ANTIK	SAINT F					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 560	O Continued From page 4		2 560			
	undated, directed star resident's program, a will be implemented.	n appropriate plan of care Resident's individual be on the nursing assistant's				
	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:					
	6/12/16, revealed R13 incontinent (less than incontinence). R13's	7 documented episodes of quarterly MDS, dated 3 was frequently incontinent nted episodes of				
	revealed R13 did not	plan, initiated 6/20/16, have a bladder incontinence il 10/19/16.				
	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."					

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Minnesota Department of Health

1 ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		00997	B. WING		10/2	20/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ST ANTH	ONY PARK HOME		MONWEALTH A JL, MN 55108	AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE	
2 560	instructions related to On 10/19/16, at 9:33 at (NA)-C was observed incontinence brief and toilet. R13 noted her in NA-C then assisted Recare. After assisting Freported R13's incontiand she assisted with NA-C reported R13 with she needed to use the On 10/19/16, at 1:32 at (RN)-B and (RN)-C comprehensive care in for R13. RN-C and RI (nursing assistant) day explained it was a cart assistants, not a compand RN-C confirmed indicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the intendicated R13 did not did not wear an inconto communicate the i	as of 10/20/16, revealed no urinary incontinence.  a.m. nursing assistant, assisting R13 to pull dipants down and sit on the ncontinence brief was wet. 13 with providing perineal R13 with toileting, NA-C inence brief was wet today providing perineal care. The reviewed the NAR is assignment sheet and the guide for the nursing prehensive care plan. RN-B the daily assignment sheet experience incontinence, tinence brief and was able to incontinence, tinence brief and was able to edited to void. When asked if sheet was accurate, RN-C in the results and results are guide for the nursing prehensive care plan. RN-B the daily assignment sheet experience incontinence, tinence brief and was able to void. When asked if sheet was accurate, RN-C in the results are results and RN-C in the results are results and results are results are results and results are results are results and results are results and results are results are results and results are results are results and results are results are results and results are results and results are results are results are results are results and results are r	2 560				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. WING		
		00997	B. WING		10/20/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
ST ANTHO	DNY PARK HOME		MMONWEALTH A	AVENUE	
0411.15	CHIMMA DV CT		UL, MN 55108	PROVIDER'S PLAN OF CORRECTION	0.75
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 560	Continued From page	6	2 560		
	staff to develop a care identification of all ide monitoring program of to assure ongoing and interventions in respo	ntified care needs. A ould be established in order			
2 565	Plan of Care; Use Subp. 3. Use. A com	Subp. 3 Comprehensive sprehensive plan of care ersonnel involved in the	2 565		
	by: Based on observation review, the facility fail	t is not met as evidenced  i, interview and document ed to follow the care plan daily living (ADLs) for 1 of 3 wed for ADLs.			
	Findings include:				
	(NA)-A was noted to v room to her bedroom, transfer belt around R you give me a hug?, of then assisted R54 to a pivoted her to her bed assisted R54 to roll of down and remove her	a.m. nursing assistant wheel R54 from the dining near her bed. NA-A put 154's waist and said "can can you hold onto me?", a standing position and I and to lay down. NA-A then noto her side to pull her pants incontinence brief. NA-A bottom with toilet paper. No			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00997	B. WING		10	/20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	-	
ST ANTHO	ONY PARK HOME		MMONWEALTH AV AUL, MN 55108	/ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	and assisted with brief On 10/19/16, at 10:56 needed assistance fro transfers and toileting was doing.  R54's NAR (nursing a dated 10/19/16, direct Assist" and "Bed Mob  R54's care plan, last is staff: "The resident ha performance deficit r/ Alzheimer's disease." resident requires phys turn, reposition and b Use: The resident req 2 staff for dignity toile resident requires phys with pivot transfers." 10/20/16, further direct during transfers and b striking arms, legs an or hard surface."  On 10/19/2016, at 1:3 R54 required assistar and assistance of 2 s mobility per R54's car nursing assistants sho NAR daily assignment	being transferred, turned of changes and peri-care.  a.m. NA-A reported R54 om 1-2 staff for bed mobility, depending on how she  assistant) daily assignments, ted staff: "Transferring: 2 dility: 2 Assist."  revised 10/17/16, directed as an ADL self-care at (related to) terminal and "Bed Mobility: The sical assistance by 2 staff to boost up in bed." and "Toilet duires physical assistance by ting." and "Transfer: The sical assistance of 1-2 staff. The care plan, last revised beted staff "Use caution bed mobility to prevent did hands against any sharp.  To p.m., RN-C confirmed and bed be plan. RN-C reported build follow directions on the tisheet.	2 565			
	director of nursing (Do	OD OF CORRECTION: The ON) or designee, could nt policies and procedures polementation. The DON or				

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If continuation sheet 9 of 21

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00997	B. WING		10	/20/2016	
	ROVIDER OR SUPPLIER	2237 COI	DDRESS, CITY, STAT MMONWEALTH A AUL, MN 55108	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 565	staff related to followi assurance committee audits to ensure com	de training for all nursing ng the care plan. The quality could perform random	2 565				
2 910	have a continuous promanagement to reduce unnecessary use of comprehensive resident who without an indwelling unless the resident's that catheterization who receives appropriate	e. A nursing home must ogram of bowel and bladder ce incontinence and the atheters. Based on the ent assessment, a nursing at:  o enters a nursing home catheter is not catheterized clinical condition indicates as necessary; and is incontinent of bladder treatment and services to infections and to restore as	2 910				
	by: Based on observation review, the facility fail reviewed for urinary in provided with the service.	t is not met as evidenced  n, interview, and document ed to ensure 1 of 1 residents ncontinence (R13) was vices necessary to achieve e level of bladder function.					

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6899 G1TQ11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00997	B. WING		10	0/20/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE		<i></i>
ST ANTH	ONY PARK HOME		IMONWEALTH A	AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	R13's admission Mini 6/12/16, revealed R13 incontinent (less than incontinence) and rectoilet use. R13's quarrevealed R13 was frethan 7 documented e at least one episode or required extensive as R13's urinary care are 6/15/16, revealed "Reepisodes of incontine period and was highly did receive physical are of clothing, transfers to incontinence episode at all times."  Review of R13's care revealed R13 did not care plan initiated unto Review of R13's NAR assignment sheet, darevealed the following Incontinent Products: communicate the need R13's orders, current instructions related to On 10/19/16, at 9:33 (NA)-C was observed incontinence brief and toilet. R13 noted her in NA-C then assisted R care. After assisting Freported R13's incontinenter R13's incontin	mum Data Set (MDS), dated 3 was occasionally 7 documented episodes of quired limited assistance for terly MDS, dated 9/10/16, quently incontinent (more pisodes of incontinence, but of continent voiding) and sistance for toilet use.  Lea assessment, dated esident had 2 documented ince during observation of involved in toileting task but inssistance for management it to toilet, and peri-care with its. Resident wears a pull up  plan, initiated 6/20/16, have a bladder incontinence il 10/19/16.  It (nursing assistant) daily ted October 19, 2016 g: "Incontinence: No; [blank]; Able to indicate to void-Uses call light."  as of 10/20/16, revealed no urinary incontinence.  a.m. nursing assistant,	2 910			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. Bolebino.			
		00997	B. WING		10/2	0/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST ANTHO	ONY PARK HOME		MONWEALTH . JL, MN 55108	AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 910	she needed to use the On 10/19/16, at 1:32 (RN)-B and (RN)-C concessionally incontined dated 6/12/16, and from MDS, dated 9/10/16. Unable to articulate the bladder function. RN-was no comprehensive incontinence for R13. The NAR (nursing assistants, not plan. RN-B and RN-C assignment sheet ind experience incontiner incontinence brief and the need to void. Whe assignment sheet was her shoulders. RN-B assignment sheets we past copies were not. The Bowel and Bladd undated, directed states resident's program, at will be implemented. It toileting program will care sheets and residents.	ras able to inform staff when e toilet.  p.m. registered nurses onfirmed R13 went from ent on the admission MDS, equently incontinent for the RN-B and RN-C were he reason R13 declined in B and RN-C reported there are care plan for urinary RN-C and RN-B reviewed istant) daily assignment to twas a care guide for the ent a comprehensive care acconfirmed the daily icated R13 did not not ence, did not wear and down able to communicate en asked if the daily as accurate, RN-C shrugged and RN-C reported the daily ere frequently changed and retained.  The Assessment Policy, ff: "Upon identifying in appropriate plan of care Resident's individual be on the nursing assistant's lent care plan."	2 910			
	The director of nursin staff to develop a care identification of all ide monitoring program c to assure ongoing and	entified care needs. A ould be established in order				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		00997	B. WING		10	/20/2016
	ROVIDER OR SUPPLIER	2237 CC	ADDRESS, CITY, STATE  MMONWEALTH AVIOLET, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From page	e 11	2 910			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty one				
2 920	MN Rule 4658.0525	Subp. 6 B Rehab - ADLs	2 920			
	comprehensive residence home must ensure the B. a resident who is activities of daily livin	s unable to carry out g receives the necessary good nutrition, grooming,				
	by: Based on observation review, the facility fail care and services reli	n, interview and document led to provide the necessary ated to activities of daily 3 residents (R54) reviewed				
	Findings include:					
	dated 8/28/16, reveal short term memory po- ability and severely in The MDS further indi-	from two staff for bed				
	(NA)-A was noted to room to her bedroom transfer belt around F you give me a hug?,	a.m. nursing assistant wheel R54 from the dining , near her bed. NA-A put R54's waist and said "can can you hold onto me?", a standing position and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00997	B. WING		10	)/20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
ST ANTHO	ONY PARK HOME	2237 COM	MONWEALTH	AVENUE		
		SAINT PA	UL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From page	2 12	2 920			
	assisted R54 to roll of down and remove her then cleaned R54's be other staff was preser moaned quietly while and assisted with bried On 10/19/16, at 10:56 needed assistance from transfers and toileting was doing.	being transferred, turned of changes and peri-care. S a.m. NA-A reported R54 om 1-2 staff for bed mobility, and depending on how she				
	revealed "Resident is requires staff assist w daily living). Receives bed mobility and trans extensive to total staff	ssment, dated 9/2/16, no longer ambulatory and with all ADL's (activities of s physical staff assist with all sfers." and "Requires f assistance for all toileting are, brief change, and				
		issistant] daily assignments, ted staff: "Transferring: 2 illity: 2 Assist."				
	staff: "The resident had performance deficit r/Alzheimer's disease." resident requires physicurn, reposition and buse: The resident requires 2 staff for dignity toile resident requires physicity pivot transfers." 10/20/16, further direct during transfers and buse staff: "The resident requires physicity pivot transfers."					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00997	B. WING		10/20/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ST ANTHO	ONY PARK HOME		MONWEALTH A	AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 920	Continued From page 13		2 920		
	required assistance of assistance of 2 staff of RN-C reported nursing directions on the NAF a nursing assistant not different level of care assignment sheet, the inform the nurse on the then re-evaluate and physical therapy as not suggested the suggested of the	OD OF CORRECTION: The uld re-educate all staff to egards to specific resident nd could develop a system			
21015	MN Rule 4658.0610 S Requirements- Sanit		21015		
	•	nditions. Sanitary itions must be maintained in ietary department at all			
	by: Based on observation review, the facility fail ice machines were manitary manner. This	t is not met as evidenced  n, interview and document ed to ensure the kitchen and aintained in a clean and s had the potential to affect erved food and or ice,			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER: A. BUILD			COMP	LETED
		00997	B. WING		10/	20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CT ANTH	NIV DADIZ HOME	2237 CON	IMONWEALTH A	AVENUE		
STANTHO	DNY PARK HOME	SAINT PA	UL, MN 55108			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC		COMPLETE DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
21015	5 Continued From page 14		21015			
	related to the deficien	icies noted below				
		icico notou polow.				
	Findings include:					
	On 10/17/16, at 12:30					
		around near sandwiches on				
	the counter. There was a heavy buildup of					
		he dishwasher. A disposable				
	pan was noted to be washed and put on the drying counter. The clean dishes drying counter,					
		es from the dishwasher, was				
		astic peeling off the metal				
	racks.					
	On 10/20/16 at 10:10	a.m. the dietary supervisor				
		vy buildup of orange and				
		ist on top of the dishwasher.				
		f the dishwasher and wiped				
		sed dust and crumbs to fall				
	_	e. DS was not sure what the				
	buildup of crumbs and					
		able pans were washed and				
		t food. DS confirmed the				
	drying racks had blue	plastic peeling from the				
	metal. The first floor is	ce machine was noted to				
	have orange buildup	on the upper side of the				
		f ice. On the 2nd floor, the				
		es had white, yellow, orange				
		I water chutes and on the				
	_	. DS reported she did not				
	_	and maintenance of the ice				
		The housekeeping manager				
	-	rs just wipe the outside of				
		chines. The maintenance ed he cleaned the inside of				
	0 ( , 1					
		rocedure for the 2nd floor				
		e. MM confirmed buildup of				
		and red substance in the ice				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE SU  COMPLE					
00997			B. WING			10/20/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
ST ANTHO	ONY PARK HOME		MMONWEALTH A AUL, MN 55108	AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21015	and water chutes and able to provide manu for cleaning the 2nd for cleaning from the footsupplier, printed 10/2 pans are NOT meant of the administrator and and revise cleaning processory assure that food equisanitary manner. Stanecessary. The Certif monitor food equipments of the 2nd food equipments	I tray below. MM was not facturer recommendations loor ice and water machine.  Refrigerators Policy, ff "1. Wash outside surfaces y."  od and kitchen equipment 0/16, noted "those aluminum	21015				
21375	Program  Subpart 1. Infection home must establish control program designanitary environment  This MN Requirement by: Based on interview a facility failed to ensur	Subp. 1 Infection Control;  control program. A nursing and maintain an infection gned to provide a safe and  It is not met as evidenced and document review, the pneumococcal vaccines is residents (R20, R40, R36,	21375				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
00997			B. WING		10/2	0/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ITE, ZIP CODE		
ST ANTHO	ONY PARK HOME		MONWEALTH . JL, MN 55108	AVENUE		
0(4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
21375	Continued From page	e 16	21375			
	reviewed. In addition, accurate guidelines for Vaccine (PCV)-13 as Centers for Disease 0 based on observation review, the facility fail	Control (CDC). In addition, i, interview and document ed to ensure proper cares for 2 of 4 (R54, R59)				
	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.					
	a PPSV-23 on 01/20/ record lacked evidence	acility on 5/8/14. s revealed resident received 04, however, the medical ce R40 was offered the / 23 as well as PCV-13.				
	PPSV-23 on 10/25/05	revealed R36 received a 5; however, the medical ce R36 was offered the				
	facility on 9/21/11. Im R43 received a PPSV medical record lacked the second dose of P					
	R6 admitted to the faction in the faction in the faction records	cility on 7/15/15. revealed R6 had received				

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AND BLAN OF CORRECTION INDENTIFICATION NUMBERS		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00997	B. WING		10/20/2016		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ST ANTHO	ONY PARK HOME		IMONWEALTH . UL, MN 55108	AVENUE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE	
21375	Continued From page	e 17	21375				
		accharide vaccination There was no indication and dose of PPSV 23 had					
	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."						
	resident is offered a punless the immunizate contraindicated or the immunized the resident was put the benefits and pote pneumococcal immunized will receive or PPSV 23 (Pneumoreceived the pneumoreceived the pneumorecei	nization" indicated "Each oneumococcal immunization, cion is medically eresident has already been ident or resident's legal rovided education regarding intial side effects of inization. Vaccine received either PCV 13 (Prevnar 13) ovax 23) Resident either coccal immunization or did mococcal immunization due					
	Handwashing:						
	On 10/19/16, at 9:48	a.m. nursing assistant					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
00997		00997	B. WING		10/20/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OT ANTIL	NIV DADICHOME	2237 COM	MONWEALTH .	AVENUE		
STANTHO	ONY PARK HOME	SAINT PAU	L, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
21375	Continued From page	e 18	21375			
	and applied a new brinoted R54 was contirmovement so she wo R54 again shortly. No soiled incontinence binto the bathroom and 10 seconds to R54. Nigloves. NA-B then puher call light and R54 NA-B then opened the nearby room to wash	t the blanket on R54, moved 's hands near the call light. e door and went into the hands. NA-B confirmed she but did not wash her hands				
	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					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
,			A. BUILDING: _			
		00997	B. WING		10/20/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST ANTHO	ONY PARK HOME		MONWEALTH A JL, MN 55108	AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
21375	the room with garbag the staff bathroom.  On 10/19/16, at 10:47 of nursing (RN)-E rep nursing assistants to according to how they and procedure and hat to use as appropriate  The Handwashing podirected staff "Wet had Apply soap and thoro 3. Vigorously rub han seconds generating frincluding under finger 5. Pat dry thoroughly faucet off using a pap from dirty faucet. 7. Dwaste basket. 8. Hand and after providing per between residents, be and entering a clean attended to the entering and the use of antiseptic hard sanitizer to the pwaterless hand sanitizer to the pwaterless hand sanitizer to the pwaterless hands with soa 10-15 uses of hand sanitizers. Rub until hand wash hands with soa 10-15 uses of hand sanitizers.	the nurse and then exited e and washed her hands in  If a.m. the assistant director orted she would expect wash or sanitize hands were trained per the policy and sanitizer was available with running water. 2.  Ilicy, updated 3/19/12, nds with running water. 3. Turn er towel to protect hands ispose of paper towel in ds are to be washed before ersonal cares for a resident, efore leaving a dirty area area, after removing gloves, ay also be performed with nand rub as follows: 1. Make er is removed from hands obly a dime sized amount of balm of one hand or use a zer wipe. 3. Rub hands surfaces of hands and d sanitizer is absorbed. 4. p and water after every	21375			
	could review the Pner	umococcal policies and all required information is				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2237 COMMONWEALTH AVENUE  SAINT PAUL, MN 55108   (A) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  Continued From page 20 included. Appropriate staff could be educated regarding requirements. Audits 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE COMP		
ST ANTHONY PARK HOME  2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREF	00997			B. WING 10			20/2016
SAINT PAUL, MN 55108  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21375  Continued From page 20  included. Appropriate staff could be educated regarding requirements. Audits 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							
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(21) udys.	21375	included. Appropriate regarding requiremen conducted and the recommittee meetings. designee could assur are reviewed, staff rehandwashing is conducted in the conducted and the conducted assurance reviewed, staff rehandwashing is conducted in the conducted and the conducted assurance in the conducted assurance in the conducted as a con	staff could be educated its. Audits could be could be sults reviewed at the quality The director of nursing or e that hand washing policies -trained to assure proper ucted when providing care to	21375			