DEPARTMENT OF HEALT						DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL TE SURVEY AGENCY	ID: Q84Q		
1. MEDICARE/MEDICAID PROVII (L1) 245267 2.STATE VENDOR OR MEDICAID (L2) 369742800	DER NO.	3. NAME AND ADDRESS OF FACILITY (L3) ST ANTHONY HEALTH CENTER (L4) 3700 FOSS ROAD NORTHEAST (L5) ST ANTHONY, MN			(L6) 55421	Facility ID: 00522 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 01/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	3/2014 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF		GORY 09 ESRD 10 NF 11 ICF/III 12 RHC	<u>()2</u> (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31		
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	150 (L18)150 (L17)	Complianc 1. A B. Not in Con	(IS CERTIFIED equirements the Based On: cceptable POC npliance with Prog ents and/or Appli	gram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural St 5. Life Safety Code	7. Medical Director		
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF 150		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION 1	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:		
Eva Loch, HFE NE I	Ι	0	05/05/2014	(L19)	Anne Kleppe, Enforcement Specialist 05/05/2014 (L20)			
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY		
 DETERMINATION OF ELIGIBITIES <u>X</u> 1. Facility is Eligible to <u>2</u>. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION 07/01/1984	BEGINNINC		ENDING DA		VOLUNTARY 0 01-Merger, Closure			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	· · · · · · · · · · · · · · · · · · ·		
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER		
(L27)	-	n of Admissions: uspension Date:	(L44)			07-Provider Status Change 00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	03/02/2014		(L33)	DETERMINATION APP	ROVAL		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN#24-5267

On 02/25/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on F5267022, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 01/03/14 standard survey, effective 02/07/14. Refer to the CMS 2567B for both health and life safety code.

Effective 02/07/14, the facility is certified for 50 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5267

May 5, 2014

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

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 February 7, 2014, the above facility is certified for:

151 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 151 skilled nursing facility beds.

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

Sincerely,

Are Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

May 5, 2014

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

RE: Project Number S5267025

Dear Ms. Lindig:

On January 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 3, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On February 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 13, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 7, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 3, 2014 and therefore remedies outlined in our letter to you dated January 17, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Are Klegge

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

Enclosure cc: Licensing and Certification File St Anthony Health Center May 5, 2014 Page 2

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245267	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/25/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
ST ANTHONY HEALTH CENTER			3700 FOSS ROAD NORTHEAS ST ANTHONY, MN 55421	Т

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date
ID Prefix	F0322	С	orrection ompleted 2/07/2014	ID Prefix	F0441		Correction Completed 02/07/2014	ID Prefi	F0456		Correction Completed 02/07/2014
	483.25(g)(2)			Reg. # LSC	483.65				# 483.70(c)(2)		
Reg. #		C	orrection ompleted	Reg. #			Correction Completed	Reg. a	¢		Correction Completed
ID Prefix Reg. # LSC		C	orrection ompleted				Correction Completed	Reg. a	< =		Correction Completed
Reg. #		C	orrection ompleted				Correction Completed	_	< #		Correction Completed
Reg. #		C	orrection ompleted						¢ ¢		
Reviewed E		viewed B D/AK	у	Date: 05/05/202	Signature	e of Sur	veyor:		30182	Date:	5/2014
State Agen Reviewed E CMS RO	-	viewed B	у	Date:	Signature	e of Sur	veyor:		50102	Date:	
Followup t	o Survey Compl 1/3/201								a Summary of o the Facility?	YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00522	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/25/2014
Name	e of Facility		Street Address, City, State, Zip Code	
ST ANTHONY HEALTH CENTER			3700 FOSS ROAD NORTHEAS ST ANTHONY, MN 55421	Т

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)) Date	(Y4) Item	(Y5)	Date
ID Prefix	С	orrection ompleted 2/07/2014	ID Prefix	21375	Correction Completed 02/07/2014	ID Prefix	21685	Correction Completed 02/07/2014
	MN Rule 4658.0525 Subp			MN Rule 4658.0800 Su			MN Rule 4658.141	
	C		Reg. #		Correction Completed			
ID Prefix Reg. # LSC		orrection ompleted	Reg. #					
ID Prefix Reg. # LSC		orrection ompleted	Reg. #			Reg. #		
ID Prefix Reg. # LSC	С	orrection completed	Reg. #		Correction Completed	Reg. #		
Reviewed E State Agen Reviewed E	cy GD/AK		Date: 05/05/20 Date:	Signature of Sur 14 Signature of Sur		30	Dat 0182 02 Dat	2/25/2014
CMS RO Followup to Survey Completed on: 1/3/2014 STATE FORM: REVISIT REPORT (5/99)				Check for any Unco Uncorrected Defin Page 1 of 1				

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245267	(Y2) Multiple Construction A. Building B. Wing 01 - MA	A. Building			
Name of Facility		Street Address, City, State, Zip Code			
ST ANTHONY HEALTH CENTER		3700 FOSS ROAD NORTHEAS ST ANTHONY, MN 55421	Т		

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y	5)	Date
ID Prefix		Correction Completed 02/07/2014	ID Prefix		Correction Completed 02/07/2014	ID Prefix			Correction Completed
	NFPA 101	_		NFPA 101		Reg. #			
LSC	K0029	-	LSC	K0147		LSC			_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #			D.a. #			
		-				LSC			_
		Correction			Correction				Correction
		Completed	ID Drofiv		Completed	ID Drofin			Completed
ID Prefix		_							_
Reg. # LSC		-	Reg. # LSC			Reg. # LSC			_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #			Reg. #			_
LSC		-	LSC			LSC			
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. #		-	Reg. #			Reg. #			_
			100						_
Reviewed B	By Reviewed	d By	Date:	Signature of Sur	veyor:		C	Date:	
State Agen			05/05/201	_	-	12			3/2014
Reviewed E CMS RO	By Reviewed		Date:	Signature of Sur	veyor:			Date:	
Followup t	o Survey Completed o 1/2/2014	n:		Check for any Uncon Uncorrected Defic	rrected Defic iencies (CM	iencies. Was a S-2567) Sent to		YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

May 5, 2014

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

Re: Enclosed Reinspection Results - Project Number S5267025

Dear Ms. Lindig:

On February 25, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 3, 2014, with orders received by you on January 29, 2014. At this time these correction orders were found corrected and are listed on the enclosed Revisit Report Form.

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,

Are Klegge

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

Enclosure(s) cc: Original - Facility Licensing and Certification File

DEPARTMENT OF HEALTH					CENTERS FOR ME	DICARE & MEDI	CAID SERVICES	
					AND TRANSMITTAL		ID: Q84Q	
1. MEDICARE/MEDICAID PROVIDE (L1) 245267		3. NAME AND AL (L3) ST ANTHON	DDRESS OF FAC	CILITY	TE SURVEY AGENCY	4. TYPE OF ACTI		
2.STATE VENDOR OR MEDICAID N (L2) 369742800	0.	(L4) 3700 FOSS ROAD NORTHEAST (L5) ST ANTHONY, MN			(L6) 55421	1. Initial 3. Termination 5. Validation 7. On-Site Visit	 Recertification CHOW Complaint Other 	
 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 5. DATE OF SURVEY 01/03/2014 (L34) 		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	JPPLIER CATEG 05 HHA 06 PRTF	ORY 09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA 14 CORF	8. Full Survey After Complaint		
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE	FISCAL YEAR END	DING DATE: (L35)	
11LTC PERIOD OF CERTIFICATION	1	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia			And/Or Approved Waivers Of			
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	I6. Scope of S 7. Medical D		
12.Total Facility Beds	150 (L18)		cceptable POC		4. 7-Day RN (Rural S) 5. Life Safety Code		om Size	
13.Total Certified Beds	150 (L17)	X B. Not in Con Requirement	npliance with Prog ents and/or Appli	ram ed Waivers:	* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF 150	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Jonathan Hill, HFE-NE	ll	0	2/05/2014	(L19)	Anne Kleppe, Enforcement Specialist 02/21/2014 (L20)			
PAR	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	STATE AGENCY		
 DETERMINATION OF ELIGIBIL 1. Facility is Eligible to P. 2. Facility is not Eligible 	articipate		IPLIANCE WITH ITS ACT:	I CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE		4. LTC AGREEM		26. TERMINATION ACTION	2	(L30)	
OF PARTICIPATION 07/01/1984	BEGINNINC	G DATE	ENDING DAT	ΓE	VOLUNTARY 0 01-Merger, Closure	05-Fail to	J <u>NTARY</u> 5 Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	(L44)		of other reason for whildrawar	07-Provi 00-Activ	der Status Change e	
(L27)	B. Rescind St	uspension Date:	(L44)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: Q84Q Facility ID: 00522

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS
-----------------------------	----------------------

CCN#24-5267

At the time of the 01/03/14 survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

This letter corrects and replaces the letter dated January 17, 2014.

Certified Mail # 7011 2000 0002 5143 6138

January 24, 2014

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

RE: Project Number S5267025

Dear Ms. Lindig:

On January 3, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. Please note that the previous letter stated your most serious deficiency to be at the F level, please accept our correction. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

St Anthony Health Center January 24, 2014 Page 2

<u>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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3792 Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

• State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

St Anthony Health Center January 24, 2014 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 3, 2014 (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

St Anthony Health Center January 24, 2014 Page 5 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 July 3, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

St Anthony Health Center January 24, 2014 Page 6

Feel free to contact me if you have questions.

Sincerely,

ate And ton

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	SURVEY
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A.	. Building		COMP	LETED
		245267	В.	. WING		01/	03/2014
IAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTH	ONY HEALTH CENTER				3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETI DATE
F 000	as your allegation of o Department's accepta bottom of the first pag be used as verification Upon receipt of an ac revisit of your facility r validate that substant	correction (POC) will serve compliance upon the ance. Your signature at the ge of the CMS-2567 form will n of compliance. ceptable POC an on-site		F 00	This plan of correction constitut written allegation of compliance deficiencies cited. However, sul this plan of correction is not an that a deficiency exists or that o cited correctly. This plan of corr submitted to meet the requirem established by state and federa	for the omission of admission one was ection is ents	
F 322 SS=D	483.25(g)(2) NG TRE RESTORE EATING S Based on the compre resident, the facility m (1) A resident who ha alone or with assistant tube unless the reside demonstrates that use unavoidable; and (2) A resident who is gastrostomy tube rece treatment and service pneumonia, diarrhea, metabolic abnormaliti	d to be unsubstantiated. ATMENT/SERVICES - SKILLS hensive assessment of a nust ensure that s been able to eat enough ice is not fed by naso gastric ent ' s clinical condition e of a naso gastric tube was fed by a naso-gastric or	POC W	F 32	 2 St. Anthony Health Center ensuresident who is fed by a nasogar gastrostomy tube or feeding symeccives the appropriate treatm services. The following plan wa implemented to ensure continue compliance. The Physician orders for R131 have been reviewed and revise appropriate. Physician orders have been revolver residents with G-Tubes, a made as appropriate. The facility Medication Administ G-Tubes policy has been review review. The PharMerica Nurse will conduct "Best Practices of I Administration" in-services for linurses. Nursing staff will be re-the Medication Administration: Policy. 	astric or ringe ent and s ed and R234 d as riewed for ind changes tration: wed and Consultant Medication censed educated on	

Any deficiency statement ending with an asterisk (*) denotes a denciency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or hota 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/24/2014 RMAPPROVED O. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245267	B. WING		0,	1/03/2014
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3700 FOSS ROAD NORTHEAST		
STANIHO	ONY HEALTH CENTER			ST ANTHONY, MN 55421		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 322	by: Based on observation review, the facility fail the gastrostomy tube administration of med (R131, R234) observe administration. In add mixed together during 2 residents (R234) with order. Findings include: R131's undated face to include: acute kidne hemorrhage, bronchith hemorrhage, bronchith hemorrhage. During medication ad 1/2/14, 9:22 a.m. the (LPN)-C prepared Hy (mg) (antihypertensive (glycopyrrolate used the Keppra 100 mg/1 mill epilepsy), and Cranbe LPN-C crushed the R opened the Cranberry ml Keppra, mixed all the	is not met as evidenced n, interview and document ed to check placement of (G-tube) prior to lication for 2 of 2 residents ed during G-tube medication lition, medications were a administration for 1 of the thout proper physician's sheet indicated diagnoses ey disease, subdural is and intracranial ministration observation on licensed practical nurse dralazine HCL 5 milligram e), Robinul 1 mg to treat stomach ulcer), liter (ml) 5 ml (used to treat erry 450 mg 2 capsules. obinul and Hydralazine, y capsules, measured the 5 four medications together in ic cup and added half cup of	F 32	22 Nursing Leadership will cond G-Tube medication administing per week until all licensed nu been audited. The Quality Coreview completed audit result scheduled meeting (2/18/14) further recommendations. The Director of Nursing is re- compliance with this requirer Completion date for certificat	ration audits irses have ouncil will ts at their next and make sponsible for nent. tion purposes: STVEC 5 2014	2/7/14
	tube feeding, and inje (cc) of water into the without checking for p G-tube. LPN-C used	proper placement of the the syringe to administer the s, and flushed the G-tube		Facility ID: 00522		neet Page 2 of 12

DEPARTMENT OF HEALTH AND F CENTERS FOR MEDICARE & ME				FORM	D: 01/24/2014 MAPPROVED D. 0938-0391
I I I I I I I I I I I I I I I I I I I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245267	B. WING		01/	03/2014
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
		3	700 FOSS ROAD NORTHEAST		
ST ANTHONY HEALTH CENTER		s	ST ANTHONY, MN 55421		
PREFIX (EACH DEFICIENCY ML	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 322 Continued From page 2 again with 80 cc of water verified she have not che placement prior to medic LPN-C did not know how was checked for placeme R234's undated face she to include: dysphagia, hy heart failure and metabol During medication admin 1/3/14, at 9:14 a.m. LPN- analgesic, anti-inflammat Calcium with vitamin D (s Citalopram (antidepressa (used to treat hypertensic 1 tablet, and vitamin B 10 LPN-B crushed the Aspir Metoprolol, Multivitamin a placed them in an 8 oz pl water to dissolve the mee explained the procedure tube feeding, applied the injected 5 cc air, detache G-tube, and then listened abdomen with the stethor heard a "gurgling" sound syringe with gravity to ad LPN-B stated she forgot residual before administe LPN-B pulled the plunger the stomach fluid and con then flushed the G-tube v 9:30 a.m. LPN-B stated se G-tube placement by inse G-tube placement by inse G-tube first, and then use listen to the "gurgling" so	ecked the G-tube ation administration. often R131's G-tube ent. et indicated diagnoses pertension, congestive lic encephalopathy. distration observation on -B prepared Aspirin (an tory drug) 81 mg, supplement) 500 mg, ant) 20 mg, Metoprolol on) 12.5 mg, multivitamin 200 microgram (mcg). in, Calcium, Citalopram, and Vitamin B together, lastic cup, added 6 oz of dications. LPN-B to R234, detached the syringe to the G-tube, ed the syringe from the d to the resident's scope. LPN-B stated she . LPN-B then used the minister the medications. to check the stomach ering the medications. r back and drew 20 cc of ntent into the syringe, with 150 cc water. At she usually checked erting 5 cc air into the ed the stethoscope to und. LPN-B explained "it	F 322			

Facility ID: 00522

If continuation sheet Page 3 of 12

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/24/2014 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245267	B. WING			04/02/2014	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		EET ADDRESS, CITY, STATE, ZIP CODE	ZIP CODE 01/03/2014	
ST ANTHO	ONY HEALTH CENTER						
				ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 322	Continued From pag	e 3	F	322			
		e time." LPN-B stated she		OLL			
		cement also by aspirating the					
		stated she mixed R234's					
	medications together physician's order for						
		rd indicated there was no ix the medications together.					
	1/3/14, at 9:44 a.m. a supposed to check G every procedure incl administration. DON 20 cc of air into the G gurgling sound with a if a resident was on o residual was not to b R234's medical reco needed to be given i should have not bee reviewing R131's rec although there was a R131's medications fluid restrictions, and was the medical reas medications together	S-tube placement prior to uding medication explained staff should insert G-tube, while listening to a stethoscope. Per the DON, continuous tube feeding, be checked. DON reviewed rd and stated medications ndividually to R234 and n mixed together. After cord, DON explained a physician's order to mix together, R131 was not on I DON did not know "what soning for mixing [R131's]					
	policy dated 7/23/13, medication separate Check placement be Insert 10-30 cc's air abdomen. B. Auscult	, indicated, "4. Give each ly, never mix medications. 5. fore giving medications: A. over the left quadrant of the tate with stethoscope shing or gurgling sound. C. if					
	medications or flushe	es. Notify Physician for priate. 6. Check residual					
		ment by pulling back on the					

Facility ID: 00522

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		APPROVE <u> 0. 0938-039</u> SURVEY
	CORRECTION	DENTIFICATION NUMBER:				PLETED
		245267	B. WING		01/03/20	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTHO	ONY HEALTH CENTER			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 322		e 4	F 322			
	safe, sanitary and cor to help prevent the de of disease and infecti (a) Infection Control F The facility must esta Program under which (1) Investigates, cont in the facility; (2) Decides what pro- should be applied to a (3) Maintains a record actions related to infe (b) Preventing Spread (1) When the Infection determines that a res prevent the spread of isolate the resident. (2) The facility must p communicable disease from direct contact will direct contact will trar (3) The facility must r hands after each dire hand washing is indic professional practice.	blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control nit - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections. d of Infection n Control Program ident needs isolation to f infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if nsmit the disease. equire staff to wash their ct resident contact for which cated by accepted	F 441	 St. Anthony Health Center has es and maintains an Infection Contro designed to provide a safe, sanita comfortable environment and to he prevent the development and tran of disease and infection. The follow was implemented to ensure conti- compliance. The infection control issues noted the survey were immediately correct the time of the survey. The facility Glove Use policy and has been reviewed and revised. The procedure for Dressing Changes reviewed and revised. Staff will be re-educated on Glove Use, Dress Changes, and Infection Control. Facility leadership will audit for po- breaches of infection control durin rounds five times per week until to Quality Council meeting 2/18/14. Director of Nursing will review co audits and bring any identified co- the Quality Council for further recommendations. The Executive Director is respon- compliance with this requirement Completion date for certification pro- section date for certification pro- section control date for certification pro- tion d	ol Program ary, and help hsmission bwing plan nued d during rected at procedure The facility has been e sing otential hg facility he next The mpleted ncerns to sible for	2/7/14

If continuation sheet Page 5 of 12

CENTER	MENT OF HEALTH AN	MEDICAID SERVICES					D: 01/24/2014 M APPROVED D. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245267	B. WING			01	/03/2014	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	ONY HEALTH CENTER			3	700 FOSS ROAD NORTHEAST			
STANIN	JNT HEALTH GENTER			s	ST ANTHONY, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	Continued From page	5	F	441				
	by: Based on observatio review, the facility fail dressing change tech wound contamination reviewed for wound c failed to ensure prope potential cross contar facility trash. This pra affect all 35 of 35 resi Garden Court and Su Findings include: On 1/2/14, the license was observed to com R272 without ever ch Observation on 1/2/14 wound care and a dai LPN-A completed all change without change washing hands. The f - LPN-A washed their disposable gloves, ca placed it on the bed. covers removed R272 level. - LPN-A then grabbed closer to the bed, rem threw it into the trash. soiled gloves or wash grabbed a stack of cle from a clean dressing	nique to prevent potential for 1 of 1 resident (R272) are; in addition, the facility r gloving to prevent nination when handling ctice had the potential to dents who resided in the b-Acute Units. A practical nurse (LPN)-A olete a dressing change for anging gloves. 4, at 9:00 a.m. of R272's ly dressing change revealed steps of the dressing jing the soiled gloves or ollowing was observed: hands and donned rried a dressing caddy and The bed was raised and bed 2 was asked about pain						

Event ID: Q84Q11

Facility ID: 00522

If continuation sheet Page 6 of 12

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/24/2014 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245267	B. WING			01/03/2014	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTHONY HEALTH CENTER					3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 441	the soiled gloves or w measured the wound on a piece of paper. L alginate dressing to fi on the wound and apy The dressing was dat LPN-A did not change hands prior to placing - At 9:08 a.m. LPN-A policy on changing of change. LPN-A confir soiled gloves through LPN-A acknowledged hands and donned ne soiled dressing and b On 1/2/14, at 1:45 p.m (DON) was informed and confirmed LPN-A proper infection control dressing changes. Per infection control was annually thereafter. Document review reve the facility following tr abscess on the left up at the hospital include culture of multiple org antibiotics and R272 I changes. At the facility orders included the for silver alginate dressin release that provides up to 14 days) to would	wound and without changing vashing their hands, LPN-A and wrote measurements .PN-A then cut a piece of t size of the wound, placed it plied an occlusive dressing. red with a black marker. The the soiled gloves or wash the clean wound product. was asked about the facility gloves during a dressing med he did not change the out the entire procedure. The should have washed his ew gloves after removing the efore cleaning the wound. The director of nursing of the above observation a would need "retraining" on ol procedures related to er the DON, staff training on given to staff on hire and the eated R272 was admitted to reatment at a hospital for an oper gluteal area. Treatment ed incision and drainage,	F	441			

Facility ID: 00522

If continuation sheet Page 7 of 12

			PRINTED: 01/24/2014 FORM APPROVED OMB NO. 0938-0391
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
245267	B. WING		01/03/2014
	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
	3700	FOSS ROAD NORTHEAST	
	ST A	NTHONY, MN 55421	
IUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
,	F 441		
nine, instructed staff to after removing the soiled Bullet ten instructed staff thoroughly and put on a complete the wound d dressing was removed. tions on 1/2/13, from 7:34 a janitor (H)-A was ity trash without glove non areas and utility arden Court (GC) unit and if the facility. H-A was ple door knobs and key during the observation. H-A was observed to access entrance door at GC dining area. H-A was vinyl gloves on both rge roll of clear plastic served to lift the lid of the C dining area, check the H-A the entered the soiled trooms, removed the trash ish bag into the turned to the dining area trash in the dining room e medication cart. H-A e various receptacles. s, H-A was observed to bus trash receptacles and coiled gloved hands; after clean trash bags and the m with the same soiled the was H-A observed to			
		EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CC A. BUILDING 245267 B. WING 245267 B. WING STRE 3700 ST A STRE 3700 ST A EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DIENTIFYING INFORMATION) PREFIX TAG Z F 441 Dressings, Dry/Clean : nine, instructed staff to g after removing the soiled Bullet ten instructed staff thoroughly and put on a complete the wound d dressing was removed. Attions on 1/2/13, from 7:34 a janitor (H)-A was lity trash without glove non areas and utility arden Court (GC) unit and of the facility. H-A was ple door knobs and key during the observation. H-A was observed to access entrance door at GC dining area. H-A was i vinyl gloves on both trge roll of clear plastic isserved to lift the lid of the CG dining area, check the H-A the entered the soiled trooms, removed the trash ish bag into the turned to the dining area I trash in the dining room e medication cart. H-A e various receptacles and soiled gloved hands; after clean trash bags and the m with the same soiled the was H-A observed to	EDICAID SERVICES (1) PROVDERSUPPLIENCIA DENTIFICATION NUMBER: 245267 B. WING 245267 B. WING 3TREET ADDRESS, CITY, STATE, ZIP CODE 3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421 EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DENTIFYING INFORMATION) F 441 Dressings, Dry/Clean mine, instructed staff thoroughly and put on a complete the wound d dressing was removed. Attions on 1/2/13, from 7:34 a jaintor (H)-A was tity trash without glove non areas and utility arden Court (GC) unit and of the facility. H-A was ple door knobs and key during the observation. H-A was observed to access entrance door at 3C dining area. H-A was vinvil gloves on both rige roll of clear plastic served to lift the lid of the C clining area, check the H-A the entered the solled trooms, removed the trash sh bag into the turned to the dining room e medication cart. H-A e various receptacles, h, H-A was observed to us trash receptacles and oiled gloved hands; after clean trash bags and the m with the same solled ballet ten solled ballet ten solled ballet trash bags and the m with the same solled ballet ten ballet ballet ten solled ballet ten ballet ballet ten ballet ballet ten ballet ballet ten ballet ballet ballet ten ballet ball

Facility ID: 00522

If continuation sheet Page 8 of 12

	S FOR MEDICARE &					1	<u>VO. 0938-03</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION		TE SURVEY MPLETED	
		245267	B. WING			01/03/20		
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
ST ANTH	DNY HEALTH CENTER		3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421					
(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 SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	Continued From page	e 8	F 4	41				
	before touching clean items.		14					
		yed in the access code to						
		rith soiled gloves and left GC						
	with the trash. H-A was observed to place the							
	soiled trash bags in large wheeled bin outside the							
		d the bin down hall onto						
	SAU. H-A knocked or	n the door to the Spa,						
		tely returned to the bin with						
	a bag of trash.							
		nptied the trashes at SAU						
	-	he dining area. H-A was						
		ne receptacles and to place on the nursing desk counter.						
		neeled the bin forward, then						
		the residents' coffee cart and						
		and out of the way. H-A						
	•	n of trash down SAU hallway						
	towards the front enti							
	- At 7:46 a.m. H-A int	eracted with a female staff						
		tem and placed it in the bin.						
		tered a utility room on SAU						
		erged with full trash bags.						
		rified he was wearing gloves						
		ated he usually wore gloves . H-A stated he wore the						
	-	was done collecting the						
		had not changed the soiled						
		g trash on GC. H-A stated he						
		ecting the trash of the						
	facility. H-A stated he	worked in the facility						
		ne had been trained on						
		edures for gloving and hand						
	-	on." H-A stated "sometimes"						
		gloves between rooms. H-A						
		hand washing should have						
		verified he had touched both access key pads to GC						

Facility ID: 00522

If continuation sheet Page 9 of 12

		D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/24/20 FORM APPROVE OMB NO. 0938-039	ED
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245267	B. WING		01/03/2014	
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·	
				3700 FOSS ROAD NORTHEAST		
STANIHU	ST ANTHONY HEALTH CENTER			ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			1		
F 441 F 456 SS=E	trash was picked up b morning starting at 7:1 expected janitor staff handling soiled trash is before leaving the roc or the key pads. DES trained yearly with in- DES further stated, "It cue them. Pull [staff] i and/or [provide] 1:1 tr staff should hand was hand sanitizer. The Infection Prevent for Gloves dated as a "Gloves are to be wor direct contact betwee blood, body fluids, see contaminated item, su wound dressings. Glo carefully and disposed The procedure directed the gloves. 483.70(c)(2) ESSENT OPERATING CONDIT The facility must main mechanical, electrical equipment in safe ope This REQUIREMENT by: Based on observation review, the facility fail	n. the director of es (DES) stated the facility by the janitor staff every 00 a.m. DES verified she to wear gloves when and remove the gloves orm and handling door knobs stated janitor staff was services and as needed. f I see a gloving problem, I in to sit down and council aining." DES further stated sh after glove removal or use ion Nursing Services policy pproved 6/26/12, directed, n whenever there may be n the caregiver's hands and cretions, feces, or a uch as soiled linens or oves will be removed d of in a proper container." ed how to apply and remove FIAL EQUIPMENT, SAFE TION ttain all essential , and patient care	F 4	 56 St. Anthony Health Center maintains essential mechanical, electrical, and care equipment in safe operating control The following plan was implemented ensure continued compliance. The milk cooler has been repaired. The facility's essential equipment ha inspected and repair needs have been the policy and procedure regarding maintenance requests/work orders have been reviewed and revised as approximate approximate and revised as approximate approximate and revised as approximate approximate and revised as approximate. 	patient ndition. I to s been en met. nas	

Event ID: Q84Q11

Facility ID: 00522

If continuation sheet Page 10 of 12

CENTER STATEMENT (AND PLAN OF NAME OF PI		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	A. BUILDING	E CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE 700 FOSS ROAD NORTHEAST TANTHONY, MN 55421	FORM OMB NC (X3) DATE COMF	D: 01/24/2014 MAPPROVED D: 0938-0391 SURVEY LETED 03/2014
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 456	facility. Findings include: On 12/30/13, at 12:00 dry storage room was bilateral swing (out) d two door stoppers (on The director of food si- was not aware of why would find out and the removed. -At approximately 5:30 staff wanted to ensure closed. DFS verified t be used to close the r would look at the cool notified the maintenar were being used to ke closed. Per the DFS, department should ha was not closing proper On 1/2/14, at 12:30 p. the milk cooler was of rack in front of the left manager (KM) stated stay shut, and he disc administrator and mai had reinforced with th cooler was closed and contacted an outside cooler door, but "that On 1/2/14, at 1:30 p.m	esidents who resided in the op.m. the milk cooler in the observed to have the oors wedged closed with he rubber and one wooden). ervices (DFS) stated she that had been done, but ewedges would be 0 p.m. the DFS stated the e the milk cooler stayed he door wedges should not milk cooler and maintenance ler. None of the dietary staff nee department wedges eep the milk cooler door the maintenance ave been notified the door erly. 	F 456	Staff will be inserviced regarding re maintenance needs/work orders. Facility leadership will audit for pote maintenance needs during facility rounds five times per week until the Quality Council meeting 2/18/14. Th Executive Director will review comp audits and bring any identified cond the Quality Council for further recommendations. The Executive Director is responsib compliance with this requirement. Completion date for certification put	ential next leted erns to	2/7/14

Event ID: Q84Q11

Facility ID: 00522

If continuation sheet Page 11 of 12

		ID HUMAN SERVICES): 01/24/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245267	B. WING			01/03/2014	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				37	00 FOSS ROAD NORTHEAST		
ST ANTHO	NTHONY HEALTH CENTER ST ANTHONY, MN 55421						
		ATEMENT OF DEFICIENCIES		I	PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREF		(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
					DEFICIENCY)		
F 456		e 11 mately 10:30 a.m. the ted a clarification of the issue	F	456			
		The administrator stated if					
		d properly, they did not					
		trator confirmed she had not					
	been aware the brea	d rack had been moved in					
	front of the left side d	oor of the milk cooler.					
	1/2012, did not speci	ed Raw Food Storage dated fically address milk coolers, d foods should be stored at					
	a temperature of 41 c	legrees Fahrenheit or lower.					
		policy for ensuring kitchen					
	equipment was main	tained in good working order.					
FORM CMS-250	57(02-99) Previous Versions Ob	solete Event ID: Q840	 ۱۱	Fac	ility ID: 00522 If cont	nuation shee	t Page 12 of 12

PRINTED: 01/24/2014 FORM APPROVED

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00522	B. WING		01/03/2014		
AME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	FE, ZIP CODE			
ΤΑΝΤΗ	ONY HEALTH CENTER	3700 FO	SS ROAD NORTH	IEAST			
		ST ANTH	HONY, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	JLD BE COMPLE		
2 000	Initial Comments		2 000				
	****ATTEN	VTION*****					
	NH LICENSING C	ORRECTION ORDER					
	144A.10, this correct pursuant to a survey found that the deficie herein are not correct not corrected shall be with a schedule of fir the Minnesota Depar Determination of whe corrected requires correquirements of the r number and MN Rule When a rule contains comply with any of th lack of compliance. re-inspection with an result in the assessment that was violated dur	ether a violation has been					
	that may result from orders provided that the Department withi notice of assessment INITIAL COMMENTS On 12/30/13, through Department's staff, v the following corrections corrections are comp make a copy of these original to the Minnes			Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned t Minnesota state statutes/rules for N Homes.	o		

CARAQUIT STATE FORM 2/1/14 HUM If continuation sheet 1 of 16 6899 ر

					FORI	M APPROVED
						D. 0938-0391
	IDENTIFICATION NUMBER:				COMPLETED	
	245267	B. WING _			01	/03/2014
ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ONV HEALTH CENTER			37	700 FOSS ROAD NORTHEAST		
JAT HEALTH GENTER			S	T ANTHONY, MN 55421		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
INITIAL COMMENTS		FC	000			
as your allegation of of Department's accepta bottom of the first page be used as verification Upon receipt of an acc revisit of your facility of validate that substant regulations has been your verification. In addition, complaint investigated and foun 483.25(g)(2) NG TRE RESTORE EATING S Based on the compre- resident, the facility m (1) A resident who has alone or with assistant tube unless the reside	compliance upon the ance. Your signature at the ge of the CMS-2567 form will n of compliance. acceptable POC an on-site may be conducted to ial compliance with the attained in accordance with #H5267067 was d to be unsubstantiated. ATMENT/SERVICES - SKILLS hensive assessment of a nust ensure that s been able to eat enough ace is not fed by naso gastric ent 's clinical condition	F3	322			
gastrostomy tube rec treatment and service pneumonia, diarrhea, metabolic abnormaliti	eives the appropriate es to prevent aspiration vomiting, dehydration, es, and nasal-pharyngeal					(X6) DATE
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DNY HEALTH CENTER SUMMARY STI (EACH DEFICIENCY REGULATORY OR I INITIAL COMMENTS The facility's plan of a syour allegation of a Department's accepta bottom of the first page be used as verification Upon receipt of an acc revisit of your facility in validate that substant regulations has been your verification. In addition, complaint investigated and foun 483.25(g)(2) NG TRE RESTORE EATING S Based on the compresent resident, the facility in (1) A resident who ha alone or with assistant tube unless the resided demonstrates that us unavoidable; and (2) A resident who is re- gastrostomy tube record pneumonia, diarrhea, metabolic abnormalititi ulcers and to restore,	CORRECTION IDENTIFICATION NUMBER: 245267 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition, complaint #H5267067 was investigated and found to be unsubstantiated. 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	SPOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT A. BUILDI 245267 B. WING ROVIDER OR SUPPLIER 245267 B. WING ONY HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS F 0 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. F 0 Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 3 In addition, complaint #H5267067 was investigated and found to be unsubstantiated. 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS F 3 Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal u	ES FOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ COVIDER OR SUPPLIER 245267 B. WING	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X) PROVIDERSUPPLIENCLIA (P2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING 245267 B. WING ROVIDER OR SUPPLIER 3TREET ADDRESS, CITY, STATE, 2IP CODE STANTHONY, NN 55421 STREET ADDRESS, CITY, STATE, 2IP CODE SUMMARY STATEMENT OF DEFICIENCIES IP (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC DENTERMON INFORMATION) PREFIX The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. F 000 Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 322 Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube was unavoidable; and F 322 (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration (2	MENT OF HEALTH AND HUMAN SERVICES OMB NC SFOR MEDICARE & MEDICAID SERVICES OMB NC PERFORMECTS CORRECTION 245267 8. WING 245267 8. WING 245267 8. WING 245267 8. WING 245267 8. WING 3100 FOSS ROAD NORTHEAST STREET ADDRESS, CITY, STATE, 2/P CODE 3700 FOSS ROAD NORTHEAST STANTHONY, MN 55421 SUMMARY STATEMENT OF DEFICIENCIES ILE AND PERFORMENTS REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance. In addition, compliant #H5267067 was investigated and found to be unsubstantiated. 483.25(g)(Z) NO TREATMENTSERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that - (1) A resident who has been able to eat enough alone or with sasistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate reatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and naso-gastric or gastrostomy tube receives the appropriate reatment and services to prevent aspiration pneumonia, diarrhea, womiting, dehydration, metabolic abnormalities, and naso-gastric or gastrostomy tube receives the appropriate reatment and services to prevent aspiration pneumonia, diarrhea, womiting, dehydration, metabolic abnormalines and ma

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

PRINTED: 01/24/2014

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

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/24/2014 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED	
		245267	B. WING			01/	03/2014
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
ST ANTHO	ONY HEALTH CENTER			3700 FOSS ROAD NORTH			
	1			ST ANTHONY, MN 554	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 322	Continued From page	÷ 1	F 32	2			
	by: Based on observation review, the facility fail the gastrostomy tube administration of med (R131, R234) observe administration. In add mixed together during 2 residents (R234) with order. Findings include: R131's undated face to include: acute kidne hemorrhage, bronchith hemorrhage, bronchith hemorrhage, bronchith hemorrhage, bronchith hemorrhage. During medication ad 1/2/14, 9:22 a.m. the (LPN)-C prepared Hy (mg) (antihypertensive (glycopyrrolate used the Keppra 100 mg/1 mill epilepsy), and Cranber LPN-C crushed the R opened the Cranberry ml Keppra, mixed all fan 8 ounce (oz) plasti water to dissolve the explained the procedu tube feeding, and injet (cc) of water into the 0 without checking for p G-tube. LPN-C used the	ication for 2 of 2 residents ed during G-tube medication lition, medications were g administration for 1 of the thout proper physician's sheet indicated diagnoses ey disease, subdural is and intracranial ministration observation on licensed practical nurse dralazine HCL 5 milligram e), Robinul 1 mg to treat stomach ulcer), iliter (ml) 5 ml (used to treat erry 450 mg 2 capsules. Jobinul and Hydralazine, y capsules, measured the 5 four medications together in ic cup and added half cup of medications. LPN-C ure to R131, detached the acted 120 cubic centimeters					

Facility ID: 00522

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/24/2014 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245267	B. WING			01/	03/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTHO	ONY HEALTH CENTER				3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 322	Continued From page again with 80 cc of wa verified she have not placement prior to me LPN-C did not know h was checked for place R234's undated face a to include: dysphagia, heart failure and meta During medication ad 1/3/14, at 9:14 a.m. L analgesic, anti-inflam Calcium with vitamin h Citalopram (antidepre (used to treat hyperte 1 tablet, and vitamin h Citalopram (antidepre (used to treat hyperte 1 tablet, and vitamin h LPN-B crushed the As Metoprolol, Multivitam placed them in an 8 o water to dissolve the f explained the procedu tube feeding, applied injected 5 cc air, deta G-tube, and then liste abdomen with the ste heard a "gurgling" sou syringe with gravity to LPN-B stated she forg residual before admin LPN-B pulled the plur the stomach fluid and then flushed the G-tub	a 2 ater. At 9:26 a.m. the LPN-C checked the G-tube adication administration. how often R131's G-tube ement. sheet indicated diagnoses hypertension, congestive abolic encephalopathy. ministration observation on PN-B prepared Aspirin (an matory drug) 81 mg, D (supplement) 500 mg, ssant) 20 mg, Metoprolol nsion) 12.5 mg, multivitamin 3 1000 microgram (mcg). spirin, Calcium, Citalopram, nin and Vitamin B together, z plastic cup, added 6 oz of medications. LPN-B ure to R234, detached the the syringe to the G-tube, ched the syringe from the		322	DEFICIENCY)		
	G-tube first, and then listen to the "gurgling"	inserting 5 cc air into the used the stethoscope to sound. LPN-B explained "it d to administer the air and					

Facility ID: 00522

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/24/2014 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE S COMPL	SURVEY
		245267	B. WING			01/0)3/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ST ANTHO	ONY HEALTH CENTER			3700 FOSS ROAD NORTH ST ANTHONY, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 322	usually checked place residual. LPN-B also medications together physician's order for i R234's medical recom- physician order to mix The director of nursin 1/3/14, at 9:44 a.m. a supposed to check G- every procedure inclu administration. DON 6 20 cc of air into the G gurgling sound with a if a resident was on co- residual was not to be R234's medical recom- needed to be given in should have not been reviewing R131's reco although there was a R131's medications to fluid restrictions, and was the medical reas- medication stogether. The Medication Admin policy dated 7/23/13, medication separately Check placement before Insert 10-30 cc's air o abdomen. B. Ausculta listening for a whoost no sounds are heard medications or flusher replacement if appropri	e time." LPN-B stated she ement also by aspirating the stated she mixed R234's since "there was a t." d indicated there was no k the medications together. g (DON) was interviewed on nd stated staff were -tube placement prior to dding medication explained staff should insert -tube, while listening to stethoscope. Per the DON, ontinuous tube feeding, e checked. DON reviewed d and stated medications idividually to R234 and o mixed together. After ord, DON explained physician's order to mix ogether, R131 was not on DON did not know "what oning for mixing [R131's] " nistration - Tube Feeding indicated, "4. Give each y, never mix medications: 5. ore giving medications: A. wer the left quadrant of the ate with stethoscope ning or gurgling sound. C. if	F 32	2			

Facility ID: 00522

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/24/2014 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE	
		245267	B. WING			01/0	03/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ST ANTHO	ONY HEALTH CENTER			3700 FOSS ROAD NORTH ST ANTHONY, MN 554			
					S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 322	Continued From page syringe."	2 4	F 32	2			
F 441 SS=E	483.65 INFECTION C SPREAD, LINENS	ONTROL, PREVENT	F 44	1			
	safe, sanitary and cor to help prevent the de of disease and infection (a) Infection Control F The facility must estal Program under which (1) Investigates, contr in the facility; (2) Decides what proc	gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation,					
	 (3) Maintains a record actions related to inferentiate to inferentiate to inferentiate to inferentiate the spread of th	d of Infection in Control Program ident needs isolation to infection, the facility must prohibit employees with a se or infected skin lesions th residents or their food, if asmit the disease. equire staff to wash their ct resident contact for which rated by accepted					
	transport linens so as infection.	to prevent the spread of					

Facility ID: 00522

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/24/2014 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245267	B. WING			01/	03/2014
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
				3	3700 FOSS ROAD NORTHEAST		
SIANIH	ONY HEALTH CENTER				ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page	9 5	F	441	1		
	by: Based on observation review, the facility fail dressing change tech wound contamination reviewed for wound c failed to ensure proper potential cross contar facility trash. This pra affect all 35 of 35 resi Garden Court and Su Findings include: On 1/2/14, the license was observed to com R272 without ever char Observation on 1/2/14 wound care and a dat LPN-A completed all s change without change washing hands. The f - LPN-A washed their disposable gloves, ca placed it on the bed. covers removed R272 level. - LPN-A then grabbed closer to the bed, rem threw it into the trash. soiled gloves or wash grabbed a stack of cle from a clean dressing	nique to prevent potential for 1 of 1 resident (R272) are; in addition, the facility er gloving to prevent nination when handling ctice had the potential to dents who resided in the b-Acute Units. ed practical nurse (LPN)-A plete a dressing change for anging gloves. 4, at 9:00 a.m. of R272's ly dressing change revealed steps of the dressing ging the soiled gloves or following was observed:					

Facility ID: 00522

If continuation sheet Page 6 of 12

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES			FOR	ED: 01/24/2014 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245267	B. WING		01	/03/2014
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO	DDE	
ST ANTHO	ONY HEALTH CENTER			700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(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 ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	the soiled gloves or w measured the wound on a piece of paper. L alginate dressing to fi on the wound and apy The dressing was dat LPN-A did not change hands prior to placing - At 9:08 a.m. LPN-A policy on changing of change. LPN-A confir soiled gloves through LPN-A acknowledged hands and donned ne soiled dressing and b On 1/2/14, at 1:45 p.m (DON) was informed and confirmed LPN-A proper infection control dressing changes. Per infection control was g annually thereafter. Document review reve the facility following tr abscess on the left up at the hospital include culture of multiple org antibiotics and R272 r changes. At the faciliti orders included the fo silver alginate dressin release that provides	vound and without changing rashing their hands, LPN-A and wrote measurements PN-A then cut a piece of t size of the wound, placed it olied an occlusive dressing. ed with a black marker. the soiled gloves or wash the clean wound product. was asked about the facility gloves during a dressing med he did not change the out the entire procedure. he should have washed his we gloves after removing the effore cleaning the wound. the director of nursing of the above observation would need "retraining" on ol procedures related to er the DON, staff training on given to staff on hire and ealed R272 was admitted to eatment at a hospital for an oper gluteal area. Treatment ed incision and drainage, anisms, intravenous required daily dressing y the medical doctor's llowing wound care: Apply g (controlled silver ion antimicrobial protection for nd daily, keep covered with	F 441			

If continuation sheet Page 7 of 12

		ID HUMAN SERVICES				FORM	APPROVED
			(20) MU				0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	PLETED
		245267	B. WING			01/	03/2014
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	03/2014
					700 FOSS ROAD NORTHEAST		
ST ANTHO	ONY HEALTH CENTER				ST ANTHONY, MN 55421		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	Ditte		
F 441	Continued From page	e 7	F	441			
		d Dressings, Dry/Clean					
	dated June 2005, bul	let nine, instructed staff to					
	pull glove over dressi	ng after removing the soiled					
	dressings and discard	 Bullet ten instructed staff 					
	to wash and dry hand	Is thoroughly and put on a					
	clean pair of gloves to	o complete the wound					
	cleaning after the soil	ed dressing was removed.					
	During random obser	vations on 1/2/13, from 7:34					
	a.m. through 7:47 a.n	n. a janitor (H)-A was					
	observed to collect fa	cility trash without glove					
	changes from the cor	nmon areas and utility					
	rooms on the secure	Garden Court (GC) unit and					
	Sub-acute Unit (SAU)) of the facility. H-A was					
	observed to touch mu	Iltiple door knobs and key					
	pads with soiled glove	es during the observation.					
	On 1/2/13, at 7:34 a.r	n. H-A was observed to					
	enter GC via a key pa	ad access entrance door at					
		e GC dining area. H-A was					
	observed to be wearing	ng vinyl gloves on both					
		large roll of clear plastic					
	•	observed to lift the lid of the					
	-	GC dining area, check the					
		d. H-A the entered the soiled					
	-	estrooms, removed the trash					
	and inserted a clean						
		returned to the dining area					
		ed trash in the dining room					
		the medication cart. H-A					
		the various receptacles.					
	-	ons, H-A was observed to					
	-	rious trash receptacles and					
	-	n soiled gloved hands; after					
		e clean trash bags and the					
		oom with the same soiled					
	•	ime was H-A observed to					
	change gloves after h	andling soiled items and/or					

Facility ID: 00522

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CENTER	MENT OF HEALTH AN		(X2) MUL	TIPLE	E CONSTRUCTION	FORM	D: 01/24/2014 APPROVED D: 0938-0391 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		245267	B. WING			01/	03/2014
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ANTHO	ONY HEALTH CENTER				3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 441	before touching clean - At 7:37 a.m. H-A key the door to the unit wi with the trash. H-A was soiled trash bags in la GC door. H-A pushed SAU. H-A knocked on entered and immediate a bag of trash. - At 7:42 a.m. H-A em nursing desk and in th observed to handle th the roll of trash bags of - At 7:44 a.m. H-A wh touched the sides of t pushed it to the side a wheeled the large bin towards the front entra- - At 7:46 a.m. H-A inter regarding a bagged it- - At 7:47 a.m. H-A ent and immediately eme - At 7:54 a.m. H-A ver in the hallway and star while collecting trash. soiled gloves until he trash and verified he f gloves after collecting was almost done colle facility. H-A stated he "almost a year" and he infection control proce washing in "orientation he would change his g was unclear on when been completed and w	items. yed in the access code to th soiled gloves and left GC as observed to place the inge wheeled bin outside the the bin down hall onto the door to the Spa, tely returned to the bin with plied the trashes at SAU he dining area. H-A was re receptacles and to place on the nursing desk counter. eeled the bin forward, then he residents' coffee cart and and out of the way. H-A of trash down SAU hallway ance. eracted with a female staff em and placed it in the bin. tered a utility room on SAU rged with full trash bags. ified he was wearing gloves ted he usually wore gloves H-A stated he wore the was done collecting the had not changed the soiled trash on GC. H-A stated he ecting the trash of the worked in the facility e had been trained on edures for gloving and hand n." H-A stated "sometimes" gloves between rooms. H-A hand washing should have verified he had touched both access key pads to GC	F	441			

If continuation sheet Page 9 of 12

	S FOR MEDICARE &					<u>10. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
		245267	B. WING		0	1/03/2014
AME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
T ANTHO	ONY HEALTH CENTER			3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 441	trash was picked up to morning starting at 7: expected janitor staff handling soiled trash before leaving the roo or the key pads. DES trained yearly with in- DES further stated, "I cue them. Pull [staff] and/or [provide] 1:1 to	n. the director of es (DES) stated the facility by the janitor staff every 00 a.m. DES verified she	F 44	1		
F 456 SS=E	for Gloves dated as a "Gloves are to be word direct contact between blood, body fluids, see contaminated item, see wound dressings. Glo carefully and dispose The procedure director the gloves.	uch as soiled linens or oves will be removed d of in a proper container." ed how to apply and remove TIAL EQUIPMENT, SAFE TION ntain all essential I, and patient care	F 45	6		
	by: Based on observatio review, the facility fail	is not met as evidenced n, interview and document led to maintain milk cooler in tion. This had the potential				

Facility ID: 00522

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/24/2014 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245267	B. WING		01	/03/2014
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	E	
ST ANTH	ONY HEALTH CENTER			700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 456	to affect 114 of 116 refacility. Findings include: On 12/30/13, at 12:00 dry storage room was bilateral swing (out) d two door stoppers (or The director of food s was not aware of why would find out and the removed. -At approximately 5:3 staff wanted to ensure closed. DFS verified t be used to close the r would look at the cool notified the maintenan were being used to ke closed. Per the DFS, department should ha was not closing prope On 1/2/14, at 12:30 p the milk cooler was ol rack in front of the leff manager (KM) stated stay shut, and he disc administrator and maintenant had reinforced with the cooler was closed and contacted an outside cooler door, but "that On 1/2/14, at 1:30 p.r	 a p.m. the milk cooler in the observed to have the oors wedged closed with he rubber and one wooden). a rubber and one wooden). a rubber and one wooden). b that had been done, but e wedges would be 0 p.m. the DFS stated the e the milk cooler stayed he door wedges should not milk cooler and maintenance ler. None of the dietary staff nee department wedges eep the milk cooler door the maintenance ave been notified the door erly. m. during the kitchen visit, beserved to have a bread to cooler door. The kitchen the left door did not want to cussed it with the intenance. KM stated he e staff to ensure the milk could be considered." n. the facility registered essential equipment such 	F 456			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/24/2014 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		245267	B. WING		_	01/0	03/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ST ANTHONY HEALTH CENTER				3700 FOSS ROAD NORTHE ST ANTHONY, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
PREFIX	(EACH DEFICIENC REGULATORY OR I Continued From page On 1/3/14, at approxin administrator request with the refrigerator. T the doors were closed re-open. The adminis been aware the bread front of the left side do The facility policy title 1/2012, did not specif but stated refrigerated a temperature of 41 d The facility lacked a p	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) a 11 mately 10:30 a.m. the ed a clarification of the issue The administrator stated if d properly, they did not trator confirmed she had not d rack had been moved in	PREFIX	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		COMPLETION

Facility ID: 00522

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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8279

January 17, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5267025

Dear Ms. Lindig:

The above facility was surveyed on December 30, 2013 through January 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

St Anthony Health Center January 17, 2014 Page 2

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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Po Box 64900, St Paul MN 55164-0900. 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,

Kumalu Fiske Downing

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

Enclosure(s) cc: Original - Facility Licensing and Certification File