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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q84Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00522

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/03/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **150** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

Program Requirements Compliance Based On:
1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Eva Loch, HFE NE II 05/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/05/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1984** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
03/02/2014 (L33)

DETERMINATION APPROVAL

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,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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, effective February 7, 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,

Anne Kleppe

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: anne.kleppe@state.mn.us

Enclosure
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245267	A. Building B. Wing	2/25/2014

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0322 Reg. # 483.25(g)(2) LSC	02/07/2014	ID Prefix F0441 Reg. # 483.65 LSC	02/07/2014	ID Prefix F0456 Reg. # 483.70(c)(2) LSC	02/07/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	05/05/2014	30182	02/25/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
1/3/2014	

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00522	A. Building B. Wing	2/25/2014

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

This report is completed by a 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 **20930** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **02/07/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **02/07/2014**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **02/07/2014**
ID Prefix **21710** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **02/07/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	05/05/2014	30182	02/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/3/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245267	A. Building 01 - MAIN BUILDING 01 B. Wing	2/13/2014

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	02/07/2014	ID Prefix Reg. # NFPA 101 LSC K0147	02/07/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/AK	05/05/2014	12424	02/13/2014
Reviewed By CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
1/2/2014	

MINNESOTA
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DEPARTMENT OF HEALTH

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,

Anne Kleppe

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: anne.kleppe@state.mn.us

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q84Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00522

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245267**
2.STATE VENDOR OR MEDICAID NO.
(L2) **369742800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **150** (L18)

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

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jonathan Hill, HFE-NE II 02/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/21/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	01/03/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility 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.	F 000	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by state and federal law.	
F 322 SS=D	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 skills.	F 322	St. Anthony Health Center ensures that a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services. The following plan was implemented to ensure continued compliance. The Physician orders for R131 and R234 have been reviewed and revised as appropriate. Physician orders have been reviewed for other residents with G-Tubes, and changes made as appropriate. The facility Medication Administration: G-Tubes policy has been reviewed and revised. The PharMerica Nurse Consultant will conduct "Best Practices of Medication Administration" in-services for licensed nurses. Nursing staff will be re-educated on the Medication Administration: G-Tubes Policy.	

POC accepted KS Jan 10 215114

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	2/1/14

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

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F 322	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to check placement of the gastrostomy tube (G-tube) prior to administration of medication for 2 of 2 residents (R131, R234) observed during G-tube medication administration. In addition, medications were mixed together during administration for 1 of the 2 residents (R234) without proper physician's order. Findings include: R131's undated face sheet indicated diagnoses to include: acute kidney disease, subdural hemorrhage, bronchitis and intracranial hemorrhage. During medication administration observation on 1/2/14, 9:22 a.m. the licensed practical nurse (LPN)-C prepared Hydralazine HCL 5 milligram (mg) (antihypertensive), Robinul 1 mg (glycopyrrolate used to treat stomach ulcer), Keppra 100 mg/1 milliliter (ml) 5 ml (used to treat epilepsy), and Cranberry 450 mg 2 capsules. LPN-C crushed the Robinul and Hydralazine, opened the Cranberry capsules, measured the 5 ml Keppra, mixed all four medications together in an 8 ounce (oz) plastic cup and added half cup of water to dissolve the medications. LPN-C explained the procedure to R131, detached the tube feeding, and injected 120 cubic centimeters (cc) of water into the G-tube with a syringe without checking for proper placement of the G-tube. LPN-C used the syringe to administer the dissolved medications, and flushed the G-tube	F 322	Nursing Leadership will conduct five G-Tube medication administration audits per week until all licensed nurses have been audited. The Quality Council will review completed audit results at their next scheduled meeting (2/18/14) and make further recommendations. The Director of Nursing is responsible for compliance with this requirement. Completion date for certification purposes:	2/7/14

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F 322	Continued From page 2	F 322		

again with 80 cc of water. At 9:26 a.m. the LPN-C verified she have not checked the G-tube placement prior to medication administration. LPN-C did not know how often R131's G-tube was checked for placement.

R234's undated face sheet indicated diagnoses to include: dysphagia, hypertension, congestive heart failure and metabolic encephalopathy.

During medication administration observation on 1/3/14, at 9:14 a.m. LPN-B prepared Aspirin (an analgesic, anti-inflammatory drug) 81 mg, Calcium with vitamin D (supplement) 500 mg, Citalopram (antidepressant) 20 mg, Metoprolol (used to treat hypertension) 12.5 mg, multivitamin 1 tablet, and vitamin B 1000 microgram (mcg). LPN-B crushed the Aspirin, Calcium, Citalopram, Metoprolol, Multivitamin and Vitamin B together, placed them in an 8 oz plastic cup, added 6 oz of water to dissolve the medications. LPN-B explained the procedure to R234, detached the tube feeding, applied the syringe to the G-tube, injected 5 cc air, detached the syringe from the G-tube, and then listened to the resident's abdomen with the stethoscope. LPN-B stated she heard a "gurgling" sound. LPN-B then used the syringe with gravity to administer the medications. LPN-B stated she forgot to check the stomach residual before administering the medications. LPN-B pulled the plunger back and drew 20 cc of the stomach fluid and content into the syringe, then flushed the G-tube with 150 cc water. At 9:30 a.m. LPN-B stated she usually checked G-tube placement by inserting 5 cc air into the G-tube first, and then used the stethoscope to listen to the "gurgling" sound. LPN-B explained "it would have been hard to administer the air and

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F 322	Continued From page 3	F 322		

listen to it at the same time." LPN-B stated she usually checked placement also by aspirating the residual. LPN-B also stated she mixed R234's medications together since "there was a physician's order for it."

R234's medical record indicated there was no physician order to mix the medications together.

The director of nursing (DON) was interviewed on 1/3/14, at 9:44 a.m. and stated staff were supposed to check G-tube placement prior to every procedure including medication administration. DON explained staff should insert 20 cc of air into the G-tube, while listening to gurgling sound with a stethoscope. Per the DON, if a resident was on continuous tube feeding, residual was not to be checked. DON reviewed R234's medical record and stated medications needed to be given individually to R234 and should have not been mixed together. After reviewing R131's record, DON explained although there was a physician's order to mix R131's medications together, R131 was not on fluid restrictions, and DON did not know "what was the medical reasoning for mixing [R131's] medications together."

The Medication Administration - Tube Feeding policy dated 7/23/13, indicated, "4. Give each medication separately, never mix medications. 5. Check placement before giving medications: A. Insert 10-30 cc's air over the left quadrant of the abdomen. B. Auscultate with stethoscope listening for a whooshing or gurgling sound. C. if no sounds are heard do not administer medications or flushes. Notify Physician for replacement if appropriate. 6. Check residual after checking placement by pulling back on the

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F 322	Continued From page 4 syringe."	F 322		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	St. Anthony Health Center has established and maintains an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. The following plan was implemented to ensure continued compliance. The infection control issues noted during the survey were immediately corrected at the time of the survey. The facility Glove Use policy and procedure has been reviewed and revised. The facility procedure for Dressing Changes has been reviewed and revised. Staff will be re-educated on Glove Use, Dressing Changes, and Infection Control. Facility leadership will audit for potential breaches of infection control during facility rounds five times per week until the next Quality Council meeting 2/18/14. The Director of Nursing will review completed audits and bring any identified concerns to the Quality Council for further recommendations. The Executive Director is responsible for compliance with this requirement. Completion date for certification purposes:	2/7/14

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F 441	Continued From page 5	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure proper dressing change technique to prevent potential wound contamination for 1 of 1 resident (R272) reviewed for wound care; in addition, the facility failed to ensure proper gloving to prevent potential cross contamination when handling facility trash. This practice had the potential to affect all 35 of 35 residents who resided in the Garden Court and Sub-Acute Units.

Findings include:

On 1/2/14, the licensed practical nurse (LPN)-A was observed to complete a dressing change for R272 without ever changing gloves.

Observation on 1/2/14, at 9:00 a.m. of R272's wound care and a daily dressing change revealed LPN-A completed all steps of the dressing change without changing the soiled gloves or washing hands. The following was observed:
- LPN-A washed their hands and donned disposable gloves, carried a dressing caddy and placed it on the bed. The bed was raised and bed covers removed R272 was asked about pain level.
- LPN-A then grabbed the trash can to move it closer to the bed, removed the old dressing and threw it into the trash. Without changing the soiled gloves or washing their hands, LPN-A grabbed a stack of clean 4 x 4 gauze dressings from a clean dressing bin and sprayed the wound with wound cleanser; LPN-A dabbed at the wound

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F 441	Continued From page 6 with the 4 x 4's. - After cleansing the wound and without changing the soiled gloves or washing their hands, LPN-A measured the wound and wrote measurements on a piece of paper. LPN-A then cut a piece of alginate dressing to fit size of the wound, placed it on the wound and applied an occlusive dressing. The dressing was dated with a black marker. LPN-A did not change the soiled gloves or wash hands prior to placing the clean wound product. - At 9:08 a.m. LPN-A was asked about the facility policy on changing of gloves during a dressing change. LPN-A confirmed he did not change the soiled gloves throughout the entire procedure. LPN-A acknowledged he should have washed his hands and donned new gloves after removing the soiled dressing and before cleaning the wound. On 1/2/14, at 1:45 p.m. the director of nursing (DON) was informed of the above observation and confirmed LPN-A would need "retraining" on proper infection control procedures related to dressing changes. Per the DON, staff training on infection control was given to staff on hire and annually thereafter. Document review revealed R272 was admitted to the facility following treatment at a hospital for an abscess on the left upper gluteal area. Treatment at the hospital included incision and drainage, culture of multiple organisms, intravenous antibiotics and R272 required daily dressing changes. At the facility the medical doctor's orders included the following wound care: Apply silver alginate dressing (controlled silver ion release that provides antimicrobial protection for up to 14 days) to wound daily, keep covered with an occlusive dressing, change daily and as needed for soiling.	F 441		

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F 441	Continued From page 7 The facility policy titled Dressings, Dry/Clean dated June 2005, bullet nine, instructed staff to pull glove over dressing after removing the soiled dressings and discard. Bullet ten instructed staff to wash and dry hands thoroughly and put on a clean pair of gloves to complete the wound cleaning after the soiled dressing was removed. During random observations on 1/2/13, from 7:34 a.m. through 7:47 a.m. a janitor (H)-A was observed to collect facility trash without glove changes from the common 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 multiple door knobs and key pads with soiled gloves during the observation. On 1/2/13, at 7:34 a.m. H-A was observed to enter GC via a key pad access entrance door at the back aspect of the GC dining area. H-A was observed to be wearing vinyl gloves on both hands and carrying a large roll of clear plastic trash bags. H-A was observed to lift the lid of the large trash can in the GC dining area, check the trash and close the lid. H-A the entered the soiled utility room, the hall restrooms, removed the trash and inserted a clean trash bag into the receptacle. H-A then returned to the dining area and removed the soiled trash in the dining room trash receptacle and the medication cart. H-A replaced the bags in the various receptacles. During the observations, H-A was observed to directly handle the various trash receptacles and soiled trash bags with soiled gloved hands; after which H-A handled the clean trash bags and the door knobs to each room with the same soiled gloved hands. At no time was H-A observed to change gloves after handling soiled items and/or	F 441		

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F 441	Continued From page 8 before touching clean items. - At 7:37 a.m. H-A keyed in the access code to the door to the unit with soiled gloves and left GC with the trash. H-A was observed to place the soiled trash bags in large wheeled bin outside the GC door. H-A pushed the bin down hall onto SAU. H-A knocked on the door to the Spa, entered and immediately returned to the bin with a bag of trash. - At 7:42 a.m. H-A emptied the trashes at SAU nursing desk and in the dining area. H-A was observed to handle the receptacles and to place the roll of trash bags on the nursing desk counter. - At 7:44 a.m. H-A wheeled the bin forward, then touched the sides of the residents' coffee cart and pushed it to the side and out of the way. H-A wheeled the large bin of trash down SAU hallway towards the front entrance. - At 7:46 a.m. H-A interacted with a female staff regarding a bagged item and placed it in the bin. - At 7:47 a.m. H-A entered a utility room on SAU and immediately emerged with full trash bags. - At 7:54 a.m. H-A verified he was wearing gloves in the hallway and stated he usually wore gloves while collecting trash. H-A stated he wore the soiled gloves until he was done collecting the trash and verified he had not changed the soiled gloves after collecting trash on GC. H-A stated he was almost done collecting the trash of the facility. H-A stated he worked in the facility "almost a year" and he had been trained on infection control procedures for gloving and hand washing in "orientation." H-A stated "sometimes" he would change his gloves between rooms. H-A was unclear on when hand washing should have been completed and verified he had touched multiple door knobs, both access key pads to GC and other items with soiled gloved hands.	F 441		

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F 441	Continued From page 9 On 1/3/13, at 8:40 a.m. the director of environmental services (DES) stated the facility trash was picked up by the janitor staff every morning starting at 7:00 a.m. DES verified she expected janitor staff to wear gloves when handling soiled trash and remove the gloves before leaving the room and handling door knobs or the key pads. DES stated janitor staff was trained yearly with in-services and as needed. DES further stated, "If I see a gloving problem, I cue them. Pull [staff] in to sit down and council and/or [provide] 1:1 training." DES further stated staff should hand wash after glove removal or use hand sanitizer. The Infection Prevention Nursing Services policy for Gloves dated as approved 6/26/12, directed, "Gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container." The procedure directed how to apply and remove the gloves.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain milk cooler in good operating condition. This had the potential	F 456	St. Anthony Health Center maintains all essential mechanical, electrical, and patient care equipment in safe operating condition. The following plan was implemented to ensure continued compliance. The milk cooler has been repaired. The facility's essential equipment has been inspected and repair needs have been met. The policy and procedure regarding maintenance requests/work orders has been reviewed and revised as appropriate.	

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F 456	Continued From page 10 to affect 114 of 116 residents who resided in the facility. Findings include: On 12/30/13, at 12:00 p.m. the milk cooler in the dry storage room was observed to have the bilateral swing (out) doors wedged closed with two door stoppers (one rubber and one wooden). The director of food services (DFS) stated she was not aware of why that had been done, but would find out and the wedges would be removed. -At approximately 5:30 p.m. the DFS stated the staff wanted to ensure the milk cooler stayed closed. DFS verified the door wedges should not be used to close the milk cooler and maintenance would look at the cooler. None of the dietary staff notified the maintenance department wedges were being used to keep the milk cooler door closed. Per the DFS, the maintenance department should have been notified the door was not closing properly. On 1/2/14, at 12:30 p.m. during the kitchen visit, the milk cooler was observed to have a bread rack in front of the left cooler door. The kitchen manager (KM) stated the left door did not want to stay shut, and he discussed it with the administrator and maintenance. KM stated he had reinforced with the staff to ensure the milk cooler was closed and stated he had not contacted an outside vendor to repair the milk cooler door, but "that could be considered." On 1/2/14, at 1:30 p.m. the facility registered dietician (RD) verified essential equipment such as milk cooler should have properly closing doors.	F 456	Staff will be inserviced regarding reporting maintenance needs/work orders. Facility leadership will audit for potential maintenance needs during facility rounds five times per week until the next Quality Council meeting 2/18/14. The Executive Director will review completed audits and bring any identified concerns to the Quality Council for further recommendations. The Executive Director is responsible for compliance with this requirement. Completion date for certification purposes:	2/7/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 11 On 1/3/14, at approximately 10:30 a.m. the administrator requested a clarification of the issue with the refrigerator. The administrator stated if the doors were closed properly, they did not re-open. The administrator confirmed she had not been aware the bread rack had been moved in front of the left side door of the milk cooler. The facility policy titled Raw Food Storage dated 1/2012, did not specifically address milk coolers, but stated refrigerated foods should be stored at a temperature of 41 degrees Fahrenheit or lower. The facility lacked a policy for ensuring kitchen equipment was maintained in good working order.	F 456		

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	00522	A. BUILDING: _____ B. WING _____	01/03/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/30/13, through 1/3/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

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	245267	A. BUILDING _____ B. WING _____	01/03/2014

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility 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.	F 000		
F 322 SS=D	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 skills.	F 322		

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

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

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to check placement of the gastrostomy tube (G-tube) prior to administration of medication for 2 of 2 residents (R131, R234) observed during G-tube medication administration. In addition, medications were mixed together during administration for 1 of the 2 residents (R234) without proper physician's order.

Findings include:

R131's undated face sheet indicated diagnoses to include: acute kidney disease, subdural hemorrhage, bronchitis and intracranial hemorrhage.

During medication administration observation on 1/2/14, 9:22 a.m. the licensed practical nurse (LPN)-C prepared Hydralazine HCL 5 milligram (mg) (antihypertensive), Robinul 1 mg (glycopyrrolate used to treat stomach ulcer), Keppra 100 mg/1 milliliter (ml) 5 ml (used to treat epilepsy), and Cranberry 450 mg 2 capsules. LPN-C crushed the Robinul and Hydralazine, opened the Cranberry capsules, measured the 5 ml Keppra, mixed all four medications together in an 8 ounce (oz) plastic cup and added half cup of water to dissolve the medications. LPN-C explained the procedure to R131, detached the tube feeding, and injected 120 cubic centimeters (cc) of water into the G-tube with a syringe without checking for proper placement of the G-tube. LPN-C used the syringe to administer the dissolved medications, and flushed the G-tube

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again with 80 cc of water. At 9:26 a.m. the LPN-C verified she have not checked the G-tube placement prior to medication administration. LPN-C did not know how often R131's G-tube was checked for placement.

R234's undated face sheet indicated diagnoses to include: dysphagia, hypertension, congestive heart failure and metabolic encephalopathy.

During medication administration observation on 1/3/14, at 9:14 a.m. LPN-B prepared Aspirin (an analgesic, anti-inflammatory drug) 81 mg, Calcium with vitamin D (supplement) 500 mg, Citalopram (antidepressant) 20 mg, Metoprolol (used to treat hypertension) 12.5 mg, multivitamin 1 tablet, and vitamin B 1000 microgram (mcg). LPN-B crushed the Aspirin, Calcium, Citalopram, Metoprolol, Multivitamin and Vitamin B together, placed them in an 8 oz plastic cup, added 6 oz of water to dissolve the medications. LPN-B explained the procedure to R234, detached the tube feeding, applied the syringe to the G-tube, injected 5 cc air, detached the syringe from the G-tube, and then listened to the resident's abdomen with the stethoscope. LPN-B stated she heard a "gurgling" sound. LPN-B then used the syringe with gravity to administer the medications. LPN-B stated she forgot to check the stomach residual before administering the medications. LPN-B pulled the plunger back and drew 20 cc of the stomach fluid and content into the syringe, then flushed the G-tube with 150 cc water. At 9:30 a.m. LPN-B stated she usually checked G-tube placement by inserting 5 cc air into the G-tube first, and then used the stethoscope to listen to the "gurgling" sound. LPN-B explained "it would have been hard to administer the air and

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listen to it at the same time." LPN-B stated she usually checked placement also by aspirating the residual. LPN-B also stated she mixed R234's medications together since "there was a physician's order for it."

R234's medical record indicated there was no physician order to mix the medications together.

The director of nursing (DON) was interviewed on 1/3/14, at 9:44 a.m. and stated staff were supposed to check G-tube placement prior to every procedure including medication administration. DON explained staff should insert 20 cc of air into the G-tube, while listening to gurgling sound with a stethoscope. Per the DON, if a resident was on continuous tube feeding, residual was not to be checked. DON reviewed R234's medical record and stated medications needed to be given individually to R234 and should have not been mixed together. After reviewing R131's record, DON explained although there was a physician's order to mix R131's medications together, R131 was not on fluid restrictions, and DON did not know "what was the medical reasoning for mixing [R131's] medications together."

The Medication Administration - Tube Feeding policy dated 7/23/13, indicated, "4. Give each medication separately, never mix medications. 5. Check placement before giving medications: A. Insert 10-30 cc's air over the left quadrant of the abdomen. B. Auscultate with stethoscope listening for a whooshing or gurgling sound. C. if no sounds are heard do not administer medications or flushes. Notify Physician for replacement if appropriate. 6. Check residual after checking placement by pulling back on the

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F 322	Continued From page 4 syringe."	F 322		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure proper dressing change technique to prevent potential wound contamination for 1 of 1 resident (R272) reviewed for wound care; in addition, the facility failed to ensure proper gloving to prevent potential cross contamination when handling facility trash. This practice had the potential to affect all 35 of 35 residents who resided in the Garden Court and Sub-Acute Units.

Findings include:

On 1/2/14, the licensed practical nurse (LPN)-A was observed to complete a dressing change for R272 without ever changing gloves.

Observation on 1/2/14, at 9:00 a.m. of R272's wound care and a daily dressing change revealed LPN-A completed all steps of the dressing change without changing the soiled gloves or washing hands. The following was observed:
- LPN-A washed their hands and donned disposable gloves, carried a dressing caddy and placed it on the bed. The bed was raised and bed covers removed R272 was asked about pain level.
- LPN-A then grabbed the trash can to move it closer to the bed, removed the old dressing and threw it into the trash. Without changing the soiled gloves or washing their hands, LPN-A grabbed a stack of clean 4 x 4 gauze dressings from a clean dressing bin and sprayed the wound with wound cleanser; LPN-A dabbed at the wound

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with the 4 x 4's.
- After cleansing the wound and without changing the soiled gloves or washing their hands, LPN-A measured the wound and wrote measurements on a piece of paper. LPN-A then cut a piece of alginate dressing to fit size of the wound, placed it on the wound and applied an occlusive dressing. The dressing was dated with a black marker. LPN-A did not change the soiled gloves or wash hands prior to placing the clean wound product.
- At 9:08 a.m. LPN-A was asked about the facility policy on changing of gloves during a dressing change. LPN-A confirmed he did not change the soiled gloves throughout the entire procedure. LPN-A acknowledged he should have washed his hands and donned new gloves after removing the soiled dressing and before cleaning the wound.

On 1/2/14, at 1:45 p.m. the director of nursing (DON) was informed of the above observation and confirmed LPN-A would need "retraining" on proper infection control procedures related to dressing changes. Per the DON, staff training on infection control was given to staff on hire and annually thereafter.

Document review revealed R272 was admitted to the facility following treatment at a hospital for an abscess on the left upper gluteal area. Treatment at the hospital included incision and drainage, culture of multiple organisms, intravenous antibiotics and R272 required daily dressing changes. At the facility the medical doctor's orders included the following wound care: Apply silver alginate dressing (controlled silver ion release that provides antimicrobial protection for up to 14 days) to wound daily, keep covered with an occlusive dressing, change daily and as needed for soiling.

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The facility policy titled Dressings, Dry/Clean dated June 2005, bullet nine, instructed staff to pull glove over dressing after removing the soiled dressings and discard. Bullet ten instructed staff to wash and dry hands thoroughly and put on a clean pair of gloves to complete the wound cleaning after the soiled dressing was removed.

During random observations on 1/2/13, from 7:34 a.m. through 7:47 a.m. a janitor (H)-A was observed to collect facility trash without glove changes from the common 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 multiple door knobs and key pads with soiled gloves during the observation.

On 1/2/13, at 7:34 a.m. H-A was observed to enter GC via a key pad access entrance door at the back aspect of the GC dining area. H-A was observed to be wearing vinyl gloves on both hands and carrying a large roll of clear plastic trash bags. H-A was observed to lift the lid of the large trash can in the GC dining area, check the trash and close the lid. H-A the entered the soiled utility room, the hall restrooms, removed the trash and inserted a clean trash bag into the receptacle. H-A then returned to the dining area and removed the soiled trash in the dining room trash receptacle and the medication cart. H-A replaced the bags in the various receptacles. During the observations, H-A was observed to directly handle the various trash receptacles and soiled trash bags with soiled gloved hands; after which H-A handled the clean trash bags and the door knobs to each room with the same soiled gloved hands. At no time was H-A observed to change gloves after handling soiled items and/or

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before touching clean items.
- At 7:37 a.m. H-A keyed in the access code to the door to the unit with soiled gloves and left GC with the trash. H-A was observed to place the soiled trash bags in large wheeled bin outside the GC door. H-A pushed the bin down hall onto SAU. H-A knocked on the door to the Spa, entered and immediately returned to the bin with a bag of trash.
- At 7:42 a.m. H-A emptied the trashes at SAU nursing desk and in the dining area. H-A was observed to handle the receptacles and to place the roll of trash bags on the nursing desk counter.
- At 7:44 a.m. H-A wheeled the bin forward, then touched the sides of the residents' coffee cart and pushed it to the side and out of the way. H-A wheeled the large bin of trash down SAU hallway towards the front entrance.
- At 7:46 a.m. H-A interacted with a female staff regarding a bagged item and placed it in the bin.
- At 7:47 a.m. H-A entered a utility room on SAU and immediately emerged with full trash bags.
- At 7:54 a.m. H-A verified he was wearing gloves in the hallway and stated he usually wore gloves while collecting trash. H-A stated he wore the soiled gloves until he was done collecting the trash and verified he had not changed the soiled gloves after collecting trash on GC. H-A stated he was almost done collecting the trash of the facility. H-A stated he worked in the facility "almost a year" and he had been trained on infection control procedures for gloving and hand washing in "orientation." H-A stated "sometimes" he would change his gloves between rooms. H-A was unclear on when hand washing should have been completed and verified he had touched multiple door knobs, both access key pads to GC and other items with soiled gloved hands.

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F 441	Continued From page 9 On 1/3/13, at 8:40 a.m. the director of environmental services (DES) stated the facility trash was picked up by the janitor staff every morning starting at 7:00 a.m. DES verified she expected janitor staff to wear gloves when handling soiled trash and remove the gloves before leaving the room and handling door knobs or the key pads. DES stated janitor staff was trained yearly with in-services and as needed. DES further stated, "If I see a gloving problem, I cue them. Pull [staff] in to sit down and council and/or [provide] 1:1 training." DES further stated staff should hand wash after glove removal or use hand sanitizer. The Infection Prevention Nursing Services policy for Gloves dated as approved 6/26/12, directed, "Gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container." The procedure directed how to apply and remove the gloves.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain milk cooler in good operating condition. This had the potential	F 456		

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F 456	Continued From page 10 to affect 114 of 116 residents who resided in the facility. Findings include: On 12/30/13, at 12:00 p.m. the milk cooler in the dry storage room was observed to have the bilateral swing (out) doors wedged closed with two door stoppers (one rubber and one wooden). The director of food services (DFS) stated she was not aware of why that had been done, but would find out and the wedges would be removed. -At approximately 5:30 p.m. the DFS stated the staff wanted to ensure the milk cooler stayed closed. DFS verified the door wedges should not be used to close the milk cooler and maintenance would look at the cooler. None of the dietary staff notified the maintenance department wedges were being used to keep the milk cooler door closed. Per the DFS, the maintenance department should have been notified the door was not closing properly. On 1/2/14, at 12:30 p.m. during the kitchen visit, the milk cooler was observed to have a bread rack in front of the left cooler door. The kitchen manager (KM) stated the left door did not want to stay shut, and he discussed it with the administrator and maintenance. KM stated he had reinforced with the staff to ensure the milk cooler was closed and stated he had not contacted an outside vendor to repair the milk cooler door, but "that could be considered." On 1/2/14, at 1:30 p.m. the facility registered dietician (RD) verified essential equipment such as milk cooler should have properly closing doors.	F 456		

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ST ANTHONY HEALTH CENTER	3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 11 On 1/3/14, at approximately 10:30 a.m. the administrator requested a clarification of the issue with the refrigerator. The administrator stated if the doors were closed properly, they did not re-open. The administrator confirmed she had not been aware the bread rack had been moved in front of the left side door of the milk cooler. The facility policy titled Raw Food Storage dated 1/2012, did not specifically address milk coolers, but stated refrigerated foods should be stored at a temperature of 41 degrees Fahrenheit or lower. The facility lacked a policy for ensuring kitchen equipment was maintained in good working order.	F 456		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

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,

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