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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RNFO

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245063**
2.STATE VENDOR OR MEDICAID NO.
(L2) **491343400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/11/2014** (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 **84** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit completed February 11, 2014 to verify that the facility had achieved and maintained substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567B. The facility is certified for 84 skilled nursing facility beds effective February 11, 2014.

17. SURVEYOR SIGNATURE — Date :
Rebecca Wong, HFE NE II — 02/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist 04/24/2014 (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
01/04/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

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

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5063 April 24, 2014

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

Dear Mr. Barker:

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

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

Effective Februrary 11, 2014 the above facility is certified for:

84 Skilled Nursing Facility/Nursing Facility Beds

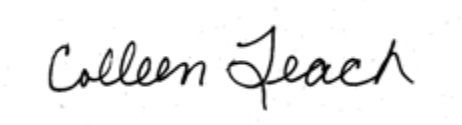
Your facility's Medicare approved area consists of all 84 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,



Colleen B. Leach, Program Specialist
Program Assurance Unit
Licensing and Certification Program

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 12, 2014

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

RE: Project Number S5063024

Dear Mr. Barker:

On December 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 11, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 17, 2013 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 December 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 27, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 19, 2013, effective February 11, 2014 and therefore remedies outlined in our letter to you dated December 26, 2013, 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

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245063	A. Building B. Wing	2/11/2014

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	01/17/2014	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	01/17/2014	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	01/17/2014
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	SR/AK	02/12/2014	30951	02/11/2014
CMS RO				

Followup to Survey Completed on: 12/19/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245063	A. Building 01 - MAIN BUILDING 01 B. Wing	1/17/2014

Name of Facility	Street Address, City, State, Zip Code
ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 12/20/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/AK	Date: 02/12/2014	Signature of Surveyor: 30951	Date: 01/17/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/19/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RNFO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00997

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245063**
2.STATE VENDOR OR MEDICAID NO.
(L2) **491343400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/19/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Candace Bolduc, HFE NE II 01/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/25/2014 (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
01/04/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

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 #: 24-5063

At the time of the December 19, 2013 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

Certified Mail # 7012 3050 0001 9094 7222

December 26, 2013

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

RE: Project Number S5063024

Dear Mr. Barker:

On December 19, 2013, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
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 January 28, 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 March 19, 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 June 19, 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,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING _____ B. WING _____	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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.	F 000	RECEIVED JAN - 7 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure oral cares were provided as directed by the care plan for 1 of 2 residents (R53); the facility failed to ensure palm protectors were applied as directed by the care plan for 1 of 2 residents (R10) reviewed for range of motion. Findings include: ORAL CARE: R53 did not receive assistance with toothbrushing according to the care plan. R53's care plan dated 7/25/12, directed staff,	F 282	1/15/14 SER St. Anthony Park Home will ensure that the care plans of resident 53 (oral care) and resident 10 (proper application of palm protector) will be followed. Resident #53's oral care will be the responsibility of the NAR taking care of the resident. The physician orders will be monitored by the licensed nurse and the nurse will need to check that the proper oral care is being performed after each meal. The oral cares for resident 53 is a part of the Physician's orders. Other residents will also be monitored, by the licensed nurse, on a daily basis to ensure the resident's oral cares are effective. All Licensed nurses and NAR's will be required to attend an in-service regarding this tag. The ADON, DON, QA or a licensed nurse not assigned to care for that resident, will monitor for compliance 7	01/17/2014

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

1-3-2014 Administrator

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING _____ B. WING _____	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 "Resident requires set-up/supervision with personal hygiene." "Resident requires cues to perform adequate hygiene." R53's care plan last revised on 12/10/13, indicated, "The resident is able to: Set-up and cue to perform cares, complete if he is unable to." On 12/18/13, at 9:11 a.m. R53 was observed to be up and dressed in the dining room having coffee. - At 9:30 a female staff said "good morning" to R53 and R53 responded with a good morning. - At 9:34 a.m. an activity staff member checked with R53 and asked if ready for church. The activity staff member walked with R53 to the elevator and down to church. - At 10:30 a.m. R53 was observed to be sitting in the first floor dining room waiting for the church service. R53 was not observed to be offered an opportunity to brush their teeth after breakfast. R53's physician orders last updated 12/18/13, indicated an order dated 8/12/13, "Staff to brush res's (resident's) teeth after every meal. Assist res if needed." R53's treatment administration record (TAR) for 12/13, indicated "Brush teeth QD. Staff to brush res's teeth after every meal. Assist res if needed." No initials signing off task noted on 12/6/13, at 8:00 a.m. and noon, or on 12/15/13, at 6:00 pm. MARs for 10/13, 9/13, 8/12/13 were reviewed and orders to brush teeth were added to MAR on 8/12/13. Missing initials for signing off task was also noted for 8:00 a.m. on 8/22/13; noon on 8/15/13 through 8/24/13, 8/26/13, and on 8/31/13. On 12/19/13, at 9:46 a.m. the licensed practical	F 282	days per week. The Palm protector will be applied to resident #10 as per physician orders. The care plan and physician orders will be consistent in directing nursing personnel to the proper location of the treatment in place at that time. The licensed nurse on the floor will need to document compliance on the treatment sheets. Other residents using palm protectors will also be monitored, by the licensed nurse on a daily basis, to ensure they are used as directed. All Licensed nurses and NAR's will be required to attend an in-service regarding this tag. The ADON, DON, or QA nurse will monitor for compliance 3 days per week. This tag will be corrected by January 17, 2014	

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F 282	Continued From page 2 nurse (LPN)-A verified R53's care plan was not followed. PALM PROTECTORS: R10 had limited range of motion (ROM) and palm protectors were not applied as directed on the care plan. R10's most recent physician orders dated as first initiated on 11/12/12, directed staff, "PALM PROTECTORS WHEN IN BED Palm protectors (blue) to be worn bilaterally for prevention of contractures and promote good skin integrity. **ONLY WHEN IN BED**." Despite the physician order for "palm protectors when in bed", R10's primary care plan dated 11/14/12, revealed, "Potential for bilateral hand contractures d/t (due to) holds hands closed secondary to dx [diagnosis] of Dementia." Interventions included, "Staff to apply palm protectors at HS [bed time] for prevention of contractures and to promote good skin integrity. Check placement of palm protectors during NOC [night] rounds." On 12/17/13, at 1:20 p.m. and again at 3:49 p.m.; on 12/19/13, at 2:00 p.m. R10 was observed to be in bed without palm protectors applied. The palm protectors were observed to be on the dresser. At 2:00 p.m. RN-A verified the palm protectors were not applied and the care plan was not followed. On 12/19/13 at 2:10 p.m. the director of nursing (DON) acknowledged R10's primary care plan and physician orders had different directions in	F 282		

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F 282	Continued From page 3 regards to the application of palm protectors. DON explained nursing assistants should the know palm protectors should be applied to R10's hands because the nurse on each unit should communicate the need to the nursing assistants.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 2 residents (R53) observed for oral care received assistance with toothbrushing after each meal as ordered to prevent dental caries. Findings include: R53's physician order dated 8/12/13, indicated, "Staff to brush res's [R53's] teeth after every meal. Assist res [resident] if needed." R53's Treatment Administration Record (TAR) for the month of 12/13, indicated, "Staff to brush res's teeth after every meal. Assist res if needed." No initials signing off task were noted on 12/6/13, at 8:00 a.m. and noon, or on 12/15/13, at 6:00 p.m. TARs for the months of 10/13, 9/13, and 8/13 were reviewed. Orders to brush teeth were added to the TAR on 8/12/13. Missing initials for signing off task was also noted for 8:00 a.m. on 8/22/13; noon on 8/15/13 through 8/24/13, 8/26/13, and 8/31/13.	F 311	St. Anthony Park Home will give the proper assistance to resident 53 to ensure that resident's teeth get brushed as directed by the care plan. Resident #53's oral care will be the responsibility of the NAR taking care of the resident. The licensed nurse will be responsible for verifying that the teeth are being properly cared for after each meal. All Licensed nurses and NAR's will be required to attend an in-service regarding this tag. The ADON, DON, QA, or a licensed nurse who is not caring for that resident, will monitor for compliance 7 days per week This tag will be corrected by January 17, 2014	01/17/2014

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F 311	Continued From page 4 On 12/16/13, at 5:46 p.m. R53's family member (FM)-A revealed R53 had new cavities and FM-A did not feel R53 was getting their teeth brushed. On 12/18/13, at 9:11 a.m. R53 was observed to be up and dressed in the dining room having coffee. - At 9:30 a female staff said "good morning" to R53 and R53 responded with a good morning. - At 9:34 a.m. an activity staff member checked with R53 and asked if ready for church. The activity staff member walked with R53 to the elevator and down to church. - At 10:30 a.m. R53 was observed to be sitting in the first floor dining room waiting for the church service. R53 was not observed to be offered an opportunity to brush their teeth after breakfast. On 12/19/13, R53 was served breakfast at 9:14 a.m. R53 finished off a cup of coffee. At 9:20 a.m. a nursing assistant (NA)-B asked R53 if would like to take a shower and R53 stated, "Yes." At no time was NA-B observed to offer assistance to R53 with teeth brushing. On 12/19/13, at 9:24 a.m. NA-A verified they had also worked with R53 on Monday. NA-A stated they had brushed R53's teeth before breakfast that morning and on Monday morning. NA-A reviewed the NA assignment sheet dated 12/19/13, and was unable to find any indication of when to brush R53's teeth. NA-A stated the NA assignment sheet only indicated one assist to help with grooming. On 12/19/13, at 9:46 a.m. the licensed practical nurse (LPN)-A revealed R53 was able to brush	F 311		

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F 311	Continued From page 5 his teeth with cues after set-up and was very cooperative. LPN-A stated there were no difficulties with R53 when asked to assist with brushing the teeth. LPN-A stated staff were supposed to brush R53's teeth after each meal, not before. LPN-A confirmed the physician order dated 8/12/13, "Staff to brush res's teeth after every meal. Assist res if needed." LPN-A also confirmed the information related to when to brush R53's teeth was not indicated on the current NA assignment sheet dated 12/19/13. The significant change Minimum Data Set (MDS) dated 7/30/13, indicated R53 required extensive assist of one staff with oral hygiene. The MDS indicated R53 had no broken or loose fitting dentures, no issues with missing teeth or abnormal mouth tissue, no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums of loose natural teeth, no mouth or facial pain, no discomfort or difficulty with chewing, and no issue with being able to examine mouth/teeth. The Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 7/31/13, indicated R53 required staff physical assist with all hygiene tasks. The CAA indicated, "Staff anticipate and meet res' needs secondary to cognitive impairment." R53's care plan dated 7/25/12, indicated, "Resident requires set-up/supervision with personal hygiene." "Resident requires cues to perform adequate hygiene." R53's care plan last revised on 12/10/13, indicated, "The resident is able to: Set-up and cue to perform cares, complete if he is unable to." R53's dental visit on 11/30/12, indicated, "Res	F 311		

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F 311	Continued From page 6 went to the dentist today. Clinical examination noticed very poor oral hygiene, heavy plaque build-up and food debris throughout dentition. Home oral care needs to be improved. Wife was concerned about the poor dentist report and said that her husband has always had good teeth. He needs a reminder to brush his teeth and he will do it. Please follow up and make sure that resident is brushing his teeth after every meal." R53's dental visit progress note dated 12/12/13, indicated the resident was unsure if they brushed or flossed. "Moderate to heavy food and plaque throughout." The note indicated clinical findings of "#32 existing amalgam (an alloy of mercury and silver used in dental fillings) has fractured, #31 has buccal caries."	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure 1 of 2 residents (R10) reviewed for range of motion (ROM) had palm protectors applied as ordered to prevent contractures (a condition of fixed high resistance to passive stretch of a muscle) of the hands.	F 318	St. Anthony Park Home will ensure that the palm protector for resident 10 will be applied as directed. The Palm protector will be applied to resident #10 as per physician orders. The care plan and physician orders will be consistent in directing nursing personnel to the proper location of the treatment in place at that time. The licensed nurse on the floor will need to document compliance on the treatment sheets. All Licensed nurses and NAR's will be required to attend an in-service regarding this tag. The ADON, DON, or QA nurse will monitor for compliance 3 days per week. This tag will be corrected by January 17, 2014	01/17/2014

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F 318	Continued From page 7 Findings include: Review of R10's most recent Minimum Data Set (MDS) dated 12/1/13, revealed an impairment in the functional ROM in both upper extremities. R10's most recent physician orders dated as first initiated on 11/12/12, directed staff, "PALM PROTECTORS WHEN IN BED Palm protectors (blue) to be worn bilaterally for prevention of contractures and promote good skin integrity. **ONLY WHEN IN BED**." Despite the physician order for "palm protectors when in bed", R10's primary care plan dated 11/14/12, revealed, "Potential for bilateral hand contractures d/t (due to) holds hands closed secondary to dx [diagnosis] of Dementia." Interventions included, "Staff to apply palm protectors at HS [bed time] for prevention of contractures and to promote good skin integrity. Check placement of palm protectors during NOC [night] rounds." R10's December 2013 treatment record directed staff, "Palm Protectors When in Bed Palm Protectors (blue) to be worn bilaterally for prevention of contractures and promote good skin integrity. **ONLY WHEN IN BED**." The record indicated Nursing staff were to initial on each shift this order was carried out for R10. During initial interview on 12/16/13, at 6:47 p.m. registered nurse (RN)-B reported R10 had potential contractures in both hands. RN-B demonstrated by showing R10's the inability to fully stretch out the fingers of R10's hands without significant resistance. RN-B reported R10 had an order for palm protectors.	F 318		

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F 318	Continued From page 8 On 12/17/13, at 1:20 p.m. R10 was observed resting in bed. Both hands were closed, R10 was not wearing palm protectors, and the palm protectors were observed on R10's dresser. At 3:49 p.m. R10 remained resting in bed with both hands closed and without palm protectors applied. On 12/19/13, at 2:00 p.m. R10 was again observed resting in bed, hands under the covers. Both palm protectors were observed on R10's dresser. At the time of the observation, registered nurse (RN)-A reported R10 had not resisted or refused care yet that day. R10's hands were observed with RN-A when R10 was in bed, RN-A verified R10 was not wearing palm protectors. Although RN-A stated R10 could be resistive to wearing palm protectors, R10 allowed both palm protectors to be applied without resistance. RN-A confirmed R10's palm protectors should be applied when R10 was in bed. The NAR [nursing assistant] Daily Assignments dated 12/19/13, included no direction related to the application of palm protectors for R10. On 12/19/13 at 2:10 p.m. the director of nursing (DON) acknowledged R10's primary care plan and physician orders had different directions in regards to the application of palm protectors. DON verified the palm protectors were not on the nursing assistant daily assignment care guide. DON explained nursing assistants should the know palm protectors should be applied to R10's hands because the nurse on each unit should communicate the need to the nursing assistants. On 12/19/13, at 2:22 p.m. the nursing assistant	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 318	Continued From page 9 (NA)-A confirmed they frequently worked with R10 and was aware R10 needed palm protectors in both hands while in bed. NA-A stated they had forgotten to apply the palm protectors for R10 before going on break at approximately 1:45 p.m. A policy on palm protectors was requested, but none was provided. An undated hand written note from occupational therapy staff (OT)-A revealed, "Palm Protectors=(No) policy as this type of Adapt. Equip. (adaptive equipment) is individually/need based."	F 318		

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	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2013**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St Anthony Park Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	POCok R 1-5-14 RECEIVED JAN - 6 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 1-28-14

Exit: 12-19-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	1-5-2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The St Anthony Park Home was constructed at three different times. The original building was built in the 1900s, is 3 stories, with a basement and was determined to be of a Type II (111) construction with a wood frame roof system that meets the exception to "The Life Safety Code" NFPA 101 (2000 edition) Section 16.1.6.2. In 1960 an addition was constructed to the west of original building, which was 1-story, with a basement, and was determined to be Type II (111) construction. In 1999 a 2nd and 3rd floor were constructed over the 1960 addition that are separated with a 2 hour fire barrier from the 1900 original building and are Type II(111) construction. The building is divided into 11 smoke zones (3 each level except the basement) by at least 1 hour fire barriers. An automatic sprinkler system is installed throughout the building. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces and	K 000		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 in all the sleeping rooms of the 1999 additions. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code. The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 79 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the patients, staff and visitors within the smoke compartment. Findings include: On facility tour between 09:00 AM and 01:00 PM on 12/19/2013, it was observed by MDH surveyor that Room 202 had electrical extension cords piggy backed together. This deficient practice was verified facility Engineer (GA).	K 147	St. Anthony Park Home will maintain electrical installations in accordance with the applicable codes. The electrical extension cords noted in room 202 have been removed and a proper surge protector has been installed in order to be in compliance. The Maintenance Director is conducting a survey of all resident rooms to ensure compliance. He will be finished with the survey of the rooms, and any improper installations will be corrected, by January 10, 2014. This tag was corrected on 12/20/2013	12/20/2013