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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: T62R

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 **05/01/2013** (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 **150** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

X 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
	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 05/02/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 05/02/2013 (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
Posted 5/22/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/08/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5267

At the time of the standard survey completed February 28, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On May 1, 2013, the Minnesota Department of Health and, on April 24, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 28, 2013, effective April 9, 2013. Therefore, the remedies outlined in our letter dated March 13, 2013, will not be imposed.
See attached CMS-2567B forms for the results of the May 1, 2013 and April 24, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5267 May 2, 2013

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

Dear Ms. Lindig:

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 April 9, 2013 the above facility is certified for:

150 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 150 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 2, 2013

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

RE: Project Number S5267024

Dear Ms. Lindig:

On March 13, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 28, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 1, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 24, 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 February 28, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 9, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 28, 2013, effective April 9, 2013 and therefore remedies outlined in our letter to you dated March 13, 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106- Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5267r113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245267	A. Building B. Wing	5/1/2013

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0154** Reg. # **483.10(b)(3), 483.10(d)(2)** LSC	Correction Completed **04/09/2013**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **04/09/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **04/09/2013**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **04/09/2013**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **04/09/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/09/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/09/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **04/09/2013**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **04/09/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/09/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/09/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/09/2013**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **04/09/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/sd	05/02/13	30182	05/01/13
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
2/28/2013			

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 B. Wing 01 - MAIN BUILDING 01	4/24/2013

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 04/09/2013	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/09/2013	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 04/09/2013
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

Reviewed By State Agency	Reviewed By PS/sd	Date: 05/02/13	Signature of Surveyor: 19251	Date: 04/24/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/27/2013		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: T62R

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 **02/28/2013** (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 **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 :
Angela Richey, HFE NE II 03/28/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/03/2013 (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
Posted 4/8/2013 ML

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 standard survey completed February 28, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 15, 2013

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

Dear Ms. Lindig:

Recently you received a CMS form 2567, written in response to a standard survey completed on February 28, 2013. Attached is a revised CMS form 2567. Page 11 on the CMS-2567 for tag F 248 should read "although R109 attended the music activity and church services according to the plan, R109 was not offered the music while he sat in the room".

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Section
Division of Compliance Monitoring
St. Paul, MN 55164-0970
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3903

March 13, 2013

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

RE: Project Number S5267024, H5267063 and H5267064

Dear Ms. Lindig:

On February 28, 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. In addition, at the time of the February 28, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5267063 and H5267064.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 28, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5267063 and H5267064 that was found to be unsubstantiated.

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

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

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

<u>Plan of Correction</u> - 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
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-37900

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 April 9, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 9, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 May 28, 2013 (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 August 28, 2013 (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:

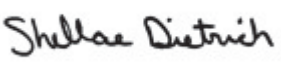
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5267s13.rtf

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 _____	02/28/2013

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. A standard recertification survey was conducted and two complaint investigations had also been completed at the time of the standard survey. An investigation of complaint H5267063 and complaint H5267064 were completed and were not substantiated.	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. RECEIVED MAR 26 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to obtain an informed consent for the use of psychotropic medication for 1 of 2	F 154	St. Anthony Health Center fully informs residents of their total health status and about care and treatment that may affect the resident's well-being. We disagree that the example listed on the CMS-2567 is evidence of any deficient practice, as the resident never received the ordered medication without his consent. However, to ensure continued compliance, the following plan was implemented. Consents were obtained for resident #R330 on 2/28/13. Medications were discontinued on 3/1/13 and 3/19/13. Resident never received any dose of either medication. The medical records of other residents with orders for psychoactive medications have been reviewed for informed consents.	

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

Executive Director | 3/25/13

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 154	Continued From page 1 residents (R330) reviewed for psychotropic use and who was newly admitted to facility on February 2013. Findings include: R330 was admitted on 2/16/13, with diagnoses of Lewy Body dementia with agitation and aggression. R330 was prescribed Zyprexa (an antipsychotic) as needed (PRN) every six hours for agitation and hallucinations and Trazadone (an antidepressant) PRN for sleep every night. Even though R330 had not received any of the medication, the facility had not obtained the informed consent for the psychoactive medication since R330 was admitted on 2/16/13 (12 days ago). The progress notes for R330 were reviewed from 2/16/13, and forward. The medical record lacked evidence that R330 was fully informed in advance about the care and treatment for the prescribed Zyprexa and Trazadone. On 2/28/13, at 11:00 a.m. registered nurse (RN) -D verified and acknowledged the guardian/ family member for R330 had not been contacted to obtain the informed consent. RN-D revealed the daughter was unavailable due to an accident and no one from the facility tried to obtain the informed consent from another family member. The director of nursing was interviewed on 2/28/13, at 12:00 p.m. and stated nursing was to inform the family and obtain the consent(s) on admit or the next day. If the consent was verbal the facility would document the verbal consent and then mail the consent for signature. The	F 154	The consulting pharmacist will continue to review residents' drug regimes monthly. Staff will be re-educated on obtaining informed consents for the use of psychoactive medications. Nursing leadership will complete one psychoactive medication audit weekly until the QA&A meeting on 4/16/13. The Director of Nursing will bring any identified audit concerns to the facility QA&A committee for review and further recommendations. The Director of Nursing remains responsible for compliance with this requirement to ensure that each resident is fully informed of their total health status, care, and treatment. See also F329. Completion date for certification purposes only:	4/9/13

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F 154	Continued From page 2 DON acknowledged and verified the informed consent for R330 was not obtained. The Psychoactive Medication Consent policy dated 11/27/12, directed the staff to obtain the informed consent prior to starting the psychoactive medication, to inform the resident that the physician had ordered the medication, the reason for the medication and the possible side effects. The form further noted the facility staff was to have the resident or legal representative sign the form according to State and Federal guidelines.	F 154		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information	F 164	St. Anthony Health Center upholds residents' rights to privacy and confidentiality. We disagree that the example listed on the CMS-2567 is evidence of any deficient practice. However, to ensure continued compliance, the following plan was implemented. The care plans and nursing assistant assignment sheets for R88 and R213 have been reviewed and updated as needed. Staff will be re-trained on providing for resident privacy using specific examples cited in the CMS-2567. Nursing leadership will complete two privacy audits per week until the next QA&A committee meeting on 4/16/13. Nursing leadership will also watch for potential privacy issues while completing various scheduled audits such as med pass audits, NAR direct care audits, etc. The Director of Nursing will review the	

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F 164	Continued From page 3 contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not maintain privacy for 2 of 5 residents (R88, R213) in the sample who were observed for cares. Findings include: R88 was observed for morning personal cares on 2/27/13, from 7:08 a.m. through 7:26 a.m. R88 shared a bathroom with an adjoining room and both bathroom doors were wide open during R88's morning personal cares. The resident was not provided for personal privacy during cares. R88 was admitted with the diagnoses of non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. The care plan dated 7/7/11, indicated the resident had a self-care deficit in bathing, dressing, and grooming (which included personal hygiene needs). The 9/11/12 and 12/4/12, quarterly Minimum Data Set (MDS) indicated the resident needed extensive assistance of one person for all cares for dressing, grooming and personal hygiene needs. The MDS dated 9/11/12, indicated the resident had moderate cognitive impairment. On 2/27/13, from 7:08 a.m. through 7:26 a.m. nursing assistant (NA)-C provided morning	F 164	completed audits and bring any identified privacy concerns to the facility QA&A committee for review and further recommendations. The Director of Nursing remains responsible for compliance with this requirement to uphold residents' rights to personal privacy and confidentiality. See also F241. Completion date for certification purposes only:	4/9/13

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F 164	Continued From page 4 personal cares for R88. It was observed R88's and the adjoining bathroom door were wide open. As NA-C exposed and washed R88's breasts and perineal area, it was noted the resident from the adjoining room was sitting on the bed reading and had a clear visual view of R88. During the observation time, NA-C went into the bathroom four times to wash hands, change gloves, or gather more personal care items. The NA did not close the adjoining bathroom door or R88's bathroom door. At 7:19 a.m. a person in the adjoining room closed the adjoining bathroom door. On 2/27/13, at 9:09 a.m. NA-C was interviewed. The NA was asked why the bathroom doors were not closed during the R88's personal cares. NA-C confirmed the bathroom doors should have been closed for the personal privacy of R88. R213 was not provided personal privacy during interview on 2/26/13, and again on 2/27/13, during personal cares the bathroom door was left open during toileting needs. R213 was admitted with diagnoses of non-Alzheimer's dementia and depression. The 11/6/12, care plan indicated the resident had a deficit in personal hygiene and required extensive assist of one staff. The 12/13/12, Vulnerable Adult assessment indicated resident had mild cognitive impairment and had visual impairment. On 2/26/13, from 7:20 a.m. through 7:54 a.m. the resident was interviewed. During the interview times at 7:30 a.m., 7:40 a.m. and 7:50 a.m. staff knocked once on the room door and immediately	F 164		

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F 164	Continued From page 5 opened the door without waiting for the resident to respond. Staff said "Oh" when they saw the visitor and the resident and quickly closed the door. At 7:40 a.m. when R213 was asked how those made her feel, R213 stated "Like it's not my home. Invasive. " On 2/27/13, at 6:24 a.m. NA-B was in R213's room to assist getting the resident ready for the weekly shower. The resident stated she needed to use the toilet and NA-B wheeled R213 into the bathroom. NA-B closed the adjoining bathroom door, however, the NA did not attempt to close R213 bathroom door. NA-B had the resident stand and then removed the soiled incontinence brief, which exposed R213's buttocks. R213's roommate was in the room in bed and had a clear visual view of R213 exposed buttocks. On 2/27/13, at 6:25 a.m. NA-B was asked why R213's bathroom door was left open. NA-B stated the "wheelchair was in the way." NA-B verified the bathroom door should have been closed for R213's privacy. On 2/27/13, at 7:35 a.m. the resident was informed the buttocks was exposed when bathroom door was left open. The resident stated, "I don't like that" and made no other comment. On 2/27/13, at 11:00 a.m. the director of nursing (DON) was interviewed and stated the facility did not have a policy and procedure specific for personal privacy. However, the DON stated the facility referred to the Resident Rights policy for direction in that area.	F 164		

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F 164	Continued From page 6 On 2/28/13, at 2:08 p.m. the staff development coordinator (SDC) was interviewed. The SDC stated the facility expectation was for staff to provide privacy by pulling curtain and closing doors. The Resident Rights Statement for Policies and Rights revision date of 1/08, was reviewed. The Treatment Privacy #12 indicated resident shall have the right to respectfulness and privacy as it relates to their personal care program. In addition, Privacy shall be respected during toileting and other activities of personal hygiene.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based observation, interview and document review, 2 of 5 residents (R88, R213) in the sample were not treated with respect during cares. Findings include: R88 had personal cares completed on 2/27/13, and staff did not inform the resident what was going to be done, performed cares in a hurried manner, did not answer the resident when questioned by the resident and had little conversation with R88 during the cares.	F 241	St. Anthony Health Center promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. We disagree that the examples listed on the CMS-2567 are evidence of any deficient practice. However, to assure continued compliance, the following plan was implemented. The care plans and nursing assistant assignment sheets for R88 and R213 have been reviewed and updated as needed. Staff will be re-trained on providing for resident privacy and dignity using specific examples cited in the CMS-2567. Nursing leadership will complete two dignity audits per week until the next QA&A committee meeting on 4/16/13. Nursing leadership will also watch for potential dignity issues while completing various scheduled audits such as med pass	

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F 241	Continued From page 7 R88 was admitted with diagnoses of non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. The care plan dated 7/7/11, indicated the resident had a self-care deficit in bathing, dressing, and grooming (which included personal hygiene needs). The 9/11/12, and 12/4/12, quarterly Minimum Data Set (MDS) indicated the resident needed extensive assistance of one person for all cares for dressing, grooming and personal hygiene needs. The 9/11/12, MDS indicated the resident had moderate cognitive impairment. On 2/27/13, from 7:08 a.m. through 7:26 a.m. nursing assistant (NA)-C was observed for morning personal cares for R88. The provision of personal cares was as followed: - At 7:08 a.m. after NA-C got a washcloth and towel ready and told R88 she was going to get her ready for breakfast. Without informing R88 what she was going to do, NA-C hurriedly washed and wiped off R88's face and did not secure the loose ends of the washcloth and towel. - At 7:10 a.m. without informing R88 NA-C loosened the incontinence pad and exposed the resident's perineal area. NA-C washed R88's perineum and R88 stated, "Please don't do that." The NA did not answer or speak with the resident. - At 7:13 a.m. NA-C told resident she was going to roll her over and without waiting for any response, NA-C rolled R88 over. As NA-C hurriedly washed and dried the buttocks area, R88 said "Ouch. " NA-C did not answer or speak with R88. As NA-C placed a clean incontinence pad, R88 again stated "Ouch " again. The NA did not speak to the resident. R88 asked NA-C how long she would be there. NA-C did not respond	F 241	audits, NAR direct care audits, etc. The Director of Nursing will review the completed audits and bring any identified dignity concerns to the facility QA&A committee for review and further recommendations. The Director of Nursing remains responsible for compliance with this requirement to ensure residents are cared for in a dignified manner. See also F164. Completion date for certification purposes only:	4/9/13

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F 241	Continued From page 8 nor speak with the resident. - At 7:18 a.m. NA-C wet and put soap on a towel and without telling R88 what she was going to do, hurriedly washed R88's chest/breast area. R88 stated "Please don't do that all over me." The NA made did not answer or speak with R88. - At 7:19 a.m. NA-C began to put on R88's front closing bra. The NA lifted the right breast and R88 yelled "Ouch." The NA gave no response to R88. NA-C then moved the bra hooks over the left breast and again R88 yelled "Ouch stop that." NA-C said "sorry" but did not talk or comfort R88. - At 7:21 a.m. without telling R88 what she was going to do, NA-C moved the deodorant stick under R88's left arm. R88 yelled "Ouch" and NA-C told R88 to move her arm (NA lifted the left arm up) so she could put on the deodorant. - At 7:24 a.m. NA-C gathered the oral care supplies. Without telling the resident what she was going to do the NA put the toothbrush up to R88's mouth. R88 resisted and NA-C then told R88 she wanted to clean her teeth and mouth and R88 complied. - At 7:26 a.m. without informing R88 what she was going to do, NA-C pulled R88's upper body up towards the pillow to lie down and R88 yelled "Oh Good God. " The NA did not speak or respond to R88 and reached for the feet to bring them up to the bed. The resident then said "Goodbye. " As R88 lay in bed, R88 made vocal sounds of "Oh, Oh, Oh. " When R88 was asked how she was and if she was comfortable, R88 made no response. On 2/28/13, at 2:01 p.m. NA-D was interviewed and stated each NA was trained to know how to do proper cares for the resident and to treat the residents with respect and dignity.	F 241		

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F 241	Continued From page 9 On 2/27/13, at 11:00 a.m. the director of nursing (DON) was interviewed and stated the facility did not have a policy and procedure specific for personal privacy. However, the DON stated the facility referred to the Resident Rights policy for direction in that area. The Resident Rights Statement for Policies and Rights revision date of 1/08, was reviewed. #2 Courteous Treatment indicated residents have the right to be treated with courtesy and respect for their individuality by employees.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities were provided based on a comprehensive assessment for 1 of 3 residents (R109) activity needs. Findings include: R109 was admitted with multiple diagnoses which included dementia and was blind in both eyes. R109 did not receive sensory services as assessed. The annual Minimum Data Set (MDS) dated	F 248	St. Anthony Health Center provides for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psycho-social well-being of each resident. We disagree that the example listed on the CMS-2567 is evidence of any deficient practice. However, to ensure continued compliance, the following plan was implemented. The most recent activity assessment for R109 was summarized in a 2/7/13 note by the Life Enrichment Coordinator, and reads, in part, "He has been meeting his other care plan goals, ... by asking staff to turn on his radio when he would like to listen to it in his room." His care plan was updated 2/28/13 to broaden the responsibility for all staff to offer to turn on music in his room. The nursing assistant care sheet has been updated with this information. The Life Enrichment Director has audited the medical records of all residents and	

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F 248	Continued From page 10 2/13/13, indicated R109 had a Brief Interview for Mental Status completed and the score for cognition was seven (which indicated severe impairment). The MDS also noted R109 had severe vision impairment and the section labeled Preferences for Customary Routine and Activities noted the most important activity for R109 to do was to listen to music.The activity care area assessment did not trigger on the MDS for R109. R109 was observed sitting in his room on 2/26/13, in the morning after breakfast and afternoon after lunch alone with no staff, visitor or staff present. Also, R109 was observed in his room after breakfast on 2/27/13. There was no sensory stimulation present as the room was void of a television. There was compact disc (CD) player behind the door which was not plugged in to the wall. The cord was wrapped around the CD player. When R109 was asked on both days if he liked to listen to music he stated, "Yes" and then replied, "I can sing if you want me to." R109 was escorted and attended both "Move and Groove" and church services on 2/27/13, at 10:00 a.m. Although R109 attended the music activity and church services according to the plan, R109 was not offered the music while he sat in the room. The activity assessment dated 2/1/13, noted R109 preferred solitary activities as well as group activities such as church and music. The assessment also indicated R109 had a current interest of music. The assessment noted a documented comment of "greatly enjoys music." Under the entertainment section was noted as current and the comment was made "especially music." The assessment lacked any summary as to what interventions were needed for R109 to	F 248	compiled a list of residents requiring the assistance of nursing staff to meet their leisure goals. The nursing assistant care sheets have been revised as appropriate. The Life Enrichment Director has educated the Life Enrichment Coordinators regarding assessment, careplanning, and properly communicating the need for assistance from other departments to meet leisure goals. The Life Enrichment Director will audit the medical record of one recent admission per week to ensure that the assessment and careplan are thorough and that the need for assistance from other departments to meet leisure goals has been properly communicated. These audits will continue until the facility QA&A meeting on 4/16/13. The facility QA&A committee will review completed audit results and make further recommendations. The Life Enrichment Director is responsible for compliance with this requirement. Completion date for certification purposes only:	4/9/13

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	245267	A. BUILDING _____ B. WING _____	02/28/2013

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F 248	Continued From page 11 obtain the music he liked to listen to and what all departments was to provide the interventions. The activity care plan printed on 2/27/13, directed the activity staff to "regularly check in with [R109] and ask if he would like music turned on." The care plan was not followed R109 did indicate that the preference for him was to listen to music and that listening to music was very important to him. The care plan lacked interventions for any other discipline to offer R109 music. The undated Nursing Assignment (NA) sheet noted R109 "liked to listen to music." However, the sheet failed to direct staff to play the CD player in R109's room or even to offer to play the CD player (according to the plan of care printed on 2/27/13) while R109 sat in his room. NA-E was interviewed on 2/27/13, at 9:59 a.m. and she indicated she had worked on that unit as a float at least five times in the past month. She commented she had never heard the CD player on. She acknowledged the CD player was not offered and not turned on for R109 to listen to while he sat in the room. The nurse practitioner was interviewed on 2/27/13, at 11:45 a.m. and indicated R109 should be listening to music. The life enrichment coordinator (LEC)-A was interviewed on 2/27/13, at 11:55 a.m. and revealed R109 was social, enjoyed exercises and group. The family also informed the facility that R109 liked to listen to music. LEC-A revealed the family brought in a CD player and a polka CD for him to listen to. On both days of the observation	F 248		

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F 248	Continued From page 12 polka was not playing. The registered nurse (RN)-C was interviewed on 2/27/13, at 11:55 a.m. RN-C indicated only certain interventions such as nursing carried over from the care plan to the kiosk. The activity interventions of the care plan would not carry over. RN-C provided a copy of the paper nursing assistant assignment sheet that is not available in kiosk. The NA sheet did not direct the staff to put music on for R109 for sensory stimulation while in his room. The director of nursing was interviewed on 2/27/13, at 2:00 p.m. She indicated R109 did like to listen to music and that the family did bring in a radio in his room for him to use.	F 248		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a temporary care plan to meet the needs of 1 of 1 resident (R329) reviewed for an automatic internal cardiac defibrillator (AICD), for the treatment of sudden cardiac arrest which would restore the hearts rhythm should the heart stop. Findings include: Record review revealed that R329 was assessed on admission to have an AICD; however, the care	F 281	The services provided by St. Anthony Health Center meet professional standards of quality. We disagree that the example listed on the CMS-2567 of a pacemaker/ AICD not careplanned is evidence of any deficient practice. However, to ensure continued compliance, the following plan was implemented. The care plan and nursing assistant assignment sheet for R329 have been reviewed and updated as needed. The care plans and nursing assistant assignment sheets for other residents with pacemakers/AICDs have been reviewed and updated as needed. Staff will be in-serviced on following care plan interventions and care of a pacemaker/AICD using specific survey	

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F 281	Continued From page 13 plan lacked any information regarding implications for provision of care. An interview was conducted with R329 on 2/28/13, at 12:45 p.m. R329 was asked about the AICD and the resident said that when the AICD goes off he jumps across the room. R329 then joked about it and stated, " You kind of have to have a sense of humor when you are as sick as I am. " An interview was conducted with the registered nurse (RN)-B on 2/28/13, at 12:57 p.m. The surveyor asked RN-B if she could tell her anything about R329's AICD and RN-B was not sure what that was, and then looked in R329's chart. RN-B checked the current care plan and could not find anything related to the AICD. An interview was conducted with Medtronic technical advisor (MTA) on 3/5/13, at 12:46 p.m. When asked about implications for care of a resident with an AICD in a nursing home, the MTA indicated the resident's cardiologist would need to be consulted for follow up care. In addition, the MTA indicated the care plan should contain information about the device so the staffs that are providing direct care would be made aware of the fact that if the device activates while providing direct care, the staff may experience a mild shock. The MTA also advised that staff should wear latex gloves to minimize the impact to direct care staff providing cares. The facility policy entitled, Computerized Care Plans dated 12/06, indicated care plans are individualized for the resident based on assessments and are revised as needed. The	F 281	findings as an example. New admissions will be audited for diagnosis of pacemaker/AICD. The facility QA&A committee will review completed audit results and make further recommendations. The Director of Nursing remains responsible for compliance with this requirement, to ensure that services meet professional standards of care. See also F309. Completion date for certification purposes only:	4/9/13

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F 281	Continued From page 14 facility did not have a policy for provision of care for residents with an AICD.	F 281		
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 failed to provide assistance with grooming for 1 of 5 residents (R41) reviewed for personal hygiene. Findings include: R41 had been admitted to the facility on 2/1/13, and stated on 2/26/13, at 9:16 a.m. that he had not had the opportunity to bath or shower since admission (for 25 days). Observation and interview was conducted on 2/26/13, at 09:16 a.m. R41 stated he had not had a single bath or shower since admit. He said, "They promised me Thursday I could take a shower". R41 said he had only been able to wash up at the sink. R41's hair was matted down upon his face and he had gray stubble on his face. Registered nurse (RN)-A was summoned and confirmed R41 should have been offered a shower by now. R41 said that each week the staff had told him the shower was not available. RN-A said the nursing assistants (NA) are responsible	F 282	The services provided by St. Anthony Health Center are provided by qualified persons in accordance with each resident's plan of care. We disagree that the example listed on the CMS-2567 is evidence of any deficient practice as there was documentation of the resident receiving two baths and no documentation that the other scheduled baths were missed. However, to ensure continued compliance, the following plan was implemented. The bathing preferences, care plan, and nursing assistant assignment sheet for R41 have been reviewed and updated as needed. The bathing preferences, care plans, and nursing assistant assignment sheets for other residents have been reviewed and updated as needed. Staff will be in-serviced on following care plan interventions, nursing assistant assignment sheets, and bath schedules using specific survey findings as an example. Nursing leadership will complete two bathing audits per week until the QA&A committee meeting on April 16, 2013. The facility QA&A committee will review completed audit results and make further recommendations.	

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F 282	Continued From page 15 for assisting a resident on their scheduled bath day. Observation on 2/27/13, at 7:02 a.m. R41 was seated on the edge of the bed waiting for help to get up. R41 was asked if he was offered a shower yesterday and he said, "Yes, finally." R41's hair was fluffed up and shiny and he had been shaved. The care plan dated 2/1/13, to present indicated R41 needed assist of one to shower due to diagnosis of Parkinson's disease. The plan of care was not followed as R41 did not receive the care and services to maintain hygiene. When interviewed on 2/28/13, at 8:55 a.m. NA-A explained how the staff use the kiosk to enter when a bath took place and then proceeded to show the surveyor a bath book in the bathroom which told the staff which day and time a resident was to receive a bath/shower. The bath book was reviewed and there were no completed bath sheets for R41. NA-A said the night shift aides were responsible to assist R41 with his shower. Copies of R41's bath sheets were requested and the medical records manager confirmed that there were no bath sheets for R41 since admit. When interviewed on 2/28/13, at 9:35 a.m. the director of nursing (DON) was asked how the facility ensured a resident would receive a shower or bath. The DON explained a bath sheet and body audit would have documentation of that and also the nurse aides use the kiosk to prompt them. When questioned about R41, the DON said he had once refused a bath because he was watching the Super Bowl. The DON said she	F 282	The Director of Nursing remains responsible for compliance with this requirement, to ensure that services are provided in accordance with each resident's plan of care. See also F311. Completion date for certification purposes only:	4/9/13

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F 282	Continued From page 16 would expect the staff to re-approach him and offer a bath again. The facility policy entitled Shower Bath dated 2/07, indicated residents would be assisted with a shower bath to maintain hygiene and healthy skin.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate care for 1 of 1 resident (R329) by not care planning an automatic internal cardiac defibrillator (AICD) for the treatment of sudden cardiac arrest which would restore the hearts rhythm should the heart stop. Findings include: Record review revealed that R329 was admitted with coronary artery disease, congestive heart failure, atrial fibrillation, aortic valve replacement and pulmonary hypertension. R329 was assessed on admission to have an AICD; however, the care plan lacked any information regarding implications for provision of care.	F 309	St. Anthony Health Center provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. We disagree that the example listed on the CMS-2567 of a pacemaker/AICD not careplanned is evidence of any deficient practice. However, to ensure continued compliance, the following plan was implemented. The care plan and nursing assistant assignment sheet for R329 have been reviewed and updated as needed. The care plans and nursing assistant assignment sheets for other residents with pacemakers/AICDs have been reviewed and updated as needed. Staff will be inserviced on following care plan interventions and care of a pacemaker/AICD using specific survey findings as an example. New admissions will be audited for diagnosis of pacemaker/AICD. The facility QA&A committee will review completed audit results and make further	

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F 309	Continued From page 17 An interview was conducted with R329 on 2/28/13 at 12:45 p.m. R329 was asked about the AICD and he stated that when it goes off he jumps across the room. R329 then joked about it and said, " You kind of have to have a sense of humor when you are as sick as I am. " According to the geriatric nurse practitioner ' s note dated 2/2/13, R329 had a history of heart disease and had a current ejection fraction (EF-an important measurement in determining how well the heart was pumping out blood and in diagnosing and tracking heart failure) of 35% (a measurement under 40 % may be evidence of heart failure). Also, the note indicated R329 had an AICD. An interview was conducted with the registered nurse (RN)-B on 2/28/13, at 12:57 p.m. The surveyor asked RN-B if she could comment on R329's AICD and RN-B was not sure what that was, and then looked in chart. She checked the current care plan and could not find anything related to the AICD. An interview was conducted with Medtronic technical advisor (MTA) on 3/5/13, at 12:46 p.m. When questioned about implications for care of a resident with an AICD in a nursing home, the MTA indicated the resident ' s cardiologist would need to be consulted for follow up care. In addition, the MTA indicated the care plan should contain information about the device so the staff who are providing direct care would be made aware of the fact that if the device activates while providing direct care, the staff may experience a mild shock. The MTA also advised that staff wear	F 309	recommendations. The Director of Nursing remains responsible for compliance with this requirement, to ensure that residents receive the necessary care and services. See also F281. Completion date for certification purposes only:	4/9/13

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F 309	Continued From page 18 latex gloves to minimize the impact to direct care staff providing cares. The facility policy entitled Computerized Care Plans dated 12/06, indicated that care plans are individualized for the resident based on assessments and are revised as needed. The facility did not have a policy for the care of residents with an AICD.	F 309		
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 provide assistance with grooming for 1 of 5 residents (R41) reviewed for personal hygiene. Findings include: R41 had been admitted to the facility on 2/1/13, and stated on 2/26/13, at 9:16 a.m. that he had not had the opportunity to bath or shower since admission (for 25 days). Observation and interview was conducted on 2/26/13, at 09:16 a.m. R41 stated he had not had a single bath or shower since admit. He said, "They promised me Thursday I could take a shower." R41 said he had only been able to wash up at the sink. R41's hair was matted down upon his face and he had gray stubble on his face.	F 311	St. Anthony Health Center provides appropriate treatment and services to maintain or improve residents' abilities. We disagree that the example listed on the CMS-2567 is evidence of any deficient practice as there was documentation of the resident receiving two baths and no documentation that the other scheduled baths were missed. However, to ensure continued compliance, the following plan was implemented. The bathing preferences, care plan, and nursing assistant assignment sheet for R41 have been reviewed and updated as needed. The bathing preferences, care plans, and nursing assistant assignment sheets for other residents have been reviewed and updated as needed. Staff will be in-serviced on following care plan interventions, nursing assistant assignment sheets, and bath schedules using specific survey findings as an example. Nursing leadership will complete two	

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F 311	Continued From page 19 Registered nurse (RN)-A was summoned and confirmed R41 should have been offered a shower by now. R41 said that each week the staff had told him the shower was not available. RN-A said the nursing assistants (NA) are responsible for assisting a resident on their scheduled bath day. Observation on 2/27/13, at 7:02 a.m. R41 was seated on the edge of the bed waiting for help to get up. R41 was asked if he was offered a shower yesterday and he said, "Yes, finally." R41's hair was fluffed up and shiny and he had been shaved. The care plan dated 2/1/13, to present indicated R41 needed assist of one to shower due to diagnosis of Parkinson's disease. R41's Vulnerable Adult Assessment dated 2/4/13, indicated R41 did not have any cognitive deficits. The admission Minimum Data Set dated 2/13/13, for Brief Interview for Mental Status (BIMS) score of 13 indicated that R41's cognition was intact and there was no evidence of delirium. When interviewed on 2/28/13, at 8:55 a.m. NA-A explained how the staff use the kiosk to enter when a bath took place and then proceeded to show the surveyor a bath book in the bathroom which told the staff which day and time a resident was to receive a bath/shower. The bath book was reviewed and there were no completed bath sheets for R41. NA-A said the night shift aides were responsible to assist R41 with his shower. Copies of R41's bath sheets were requested and the medical records manager confirmed that there were no bath sheets for R41 since admit.	F 311	bathing audits per week until the QA&A committee meeting on April 16, 2013. The facility QA&A committee will review completed audit results and make further recommendations. The Director of Nursing remains responsible for compliance with this requirement, to ensure that appropriate treatment and services are provided in accordance with each resident's plan of care. See also F282. Completion date for certification purposes only:	4/9/13

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F 311	Continued From page 20 When interviewed on 2/28/13, at 9:35 a.m. the director of nursing (DON) was asked how the facility ensured a resident would receive a shower or bath. The DON explained a bath sheet and body audit would have documentation of that and also the nurse aides use the kiosk to prompt them. When questioned about R41, the DON said he had once refused a bath because he was watching the Super Bowl. The DON said she would expect the staff to re-approach him and offer a bath again. The facility policy entitled Shower Bath dated 2/07, indicated residents would be assisted with a shower bath to maintain hygiene and healthy skin.	F 311		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutrition	F 325	St. Anthony Health Center ensures that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. St. Anthony Health Center also ensures that residents receive therapeutic diets as appropriate. Although we disagree that the example listed on the CMS-2567 is evidence of any deficient practice, the following measures were initiated to continue compliance. The facility's interdisciplinary team has has put new dietary interventions in place for R194 including scheduled afternoon and evening snacks and large portions at breakfast. The medication administration record for R194 has been updated to ensure that nurses document his supplement intake.	

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F 325	Continued From page 21 related to body weight when possible for 1 of 4 residents (R194) reviewed in the sample for nutrition. Findings include: R194's diagnoses included depressive disorder, dementia, and weakness. R194's weights were: 136 pounds (lbs.) on 1/12/13, and 119 lbs. on 2/13/13, which indicated a significant weight loss of 17 lbs. weight loss or 12.5%. R194 was not provided with adequate nutritional status to minimize weight loss. The admission Minimum Data Set dated 1/17/13, identified R194 required extensive assistance of one staff with eating, did not have any weight loss, chokes or coughs when swallowing and received a mechanically altered diet. During the observation of the noon meal on 2/27/13, at 12:44 p.m. R194 had a room tray, sitting on a folding chair next to his bed. R194's diet order slip on his tray indicated the following: Regular Diet with nectar thickened liquids. The room tray had pureed food on the plate of light brown, brownish/orange and white pureed foods. The light brown substance had a spoon sitting in the food but none of the food was eaten. R194 had a chocolate mighty shake carton on the tray that was not open. At that time, nursing assistant (NA)-K entered the room. NA-K verified R194 had pureed food on his lunch meal tray. NA-K stated R194 was on a pureed diet with thickened liquids, but did not use the diet order slip on the tray to confirm his statement. NA-K encouraged R194 to eat but he refused. NA-K then took the meal tray out of the room.	F 325	The Dietitian has audited the medical records of all residents and compiled a list of residents who are receiving dietary supplements to help prevent weight loss. The medication administration records for those residents have been updated to ensure that nurses document supplement intake. The Dietitian will review weights weekly to identify residents who have had a significant weight change. The Dietitian will reassess residents with significant weight change and adjust the plan of care as appropriate, including ensuring that any supplements are transcribed to the medication administration record for documenting intake. Nursing staff will be inserviced regarding verifying that the meals they serve residents match their diet tickets, offering alternate foods when residents do not eat what is served, as well as notifying the nurse when residents refuse a meal. The Director of Dietary Services or designee will conduct five tray audits per week to ensure that residents receive the meal appropriate to their therapeutic diets. These audits will continue until the facility QA&A meeting on 4/16/13. The facility QA&A committee will review completed audit results and make further recommendations. The Director of Dietary Services is responsible for compliance with this requirement.	

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F 325	Continued From page 22 R194 had a physician prescribed diet dated 1/10/13, for a regular diet with nectar thickened liquids. A dietary note dated 2/20/13, at 1:27 p.m. identified R194 had experienced a significant weight loss since admission to facility. It identified R194 had poor intake, he did well with breakfast intake and the other meals were marginal. The note revealed that when R194 was confronted with weight loss he seemed surprised. The dietary note identified R194 agreed to take nutrient dense meal add-ons of high calorie hot cereal, whole milk and chocolate health shakes to prevention further weight loss. R194's record lacked documentation of monitoring or evaluation of tolerance to the added interventions. On 2/27/13, at 2:14 p.m. licensed practical nurse (LPN)-K stated she was the day nurse working with R194 and nothing was reported off to her regarding his refusal for lunch. LPN-K stated R194 refused breakfast and the NA's were to inform her if residents refuse a meal, as sometimes it helps if different staff approached R194. LPN-K stated the registered dietitian added a mighty shake with his meals. LPN-K stated staff had not been recording or monitoring R194's intake of the mighty shake or other nutritional interventions. LPN-K stated some nutritional interventions were monitored for some residents and not for others. LPN-K verified R194 had a 19 pound weight loss since admission. On 2/28/13, at 12:48 p.m. the registered dietitian (RD)-A reported the cook should be providing the diet ordered on the diet order slip. RD-A pulled up	F 325	Completion date for certification purposes only:	4/9/13

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F 325	Continued From page 23 R194's diet order which indicated he was on a regular diet with thickened liquids. RD-A stated she was not sure why R194's diet was downgraded at the noon meal and confirmed it should not have been. RD-A stated R194 needs set up assistance at meals and staff needed to help him open up the mighty shake carton and pour it for him. On 2/28/13, at 1:37 p.m. RD-B stated R194 was on a nutritional supplement. RD-B stated most nutritional supplements were put on a short term monitoring list for amount taken to monitor and evaluate tolerance and effectiveness of the intervention. RD-B stated R194's nutrition interventions were not added to this monitoring list.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	St. Anthony Health Center ensures that residents are free from unnecessary drugs. We disagree that the example listed on the CMS-2567 is evidence of any deficient practice, as the resident never received the ordered medication. However, to ensure continued compliance, the following plan was implemented. Consents were obtained for R330 on 2/28/13. AIMS assessment completed 2/28/13. Medications were discontinued on 3/1/13 and 3/19/13. Resident never received a dose of either medication. The medical records of other residents with orders for psychoactive medications have been reviewed for indications for use, informed consents, AIMS, and target behaviors. The consulting pharmacist will continue to	

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F 329	Continued From page 24 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately monitor and assess clinical indications for continued use of psychoactive medications for 1 of 2 residents (R330) in the sample, who were reviewed for unnecessary medication usage and who were newly admitted in February 2013. Findings include: R330 was admitted on 2/16/13, with diagnoses of Lewy Body dementia with agitation and aggression. R330 was prescribed Zyprexa (an antipsychotic) as needed (PRN) every six hours for agitation and hallucinations and Trazadone (an antidepressant) PRN for sleep every night. The medical record lacked evidence of any monitoring of the Zyprexa, target behaviors, side effect monitoring, non-pharmacological interventions and indication for use of the Zyprexa. Even though R330 had not been in the facility for 21 days to generate a formal plan of care, R330 had a temporary plan of care printed on 2/28/13, at 11:20 a.m. The plan of care directed the staff to monitor the side effects of the medications; however, the side effects were not delineated in	F 329	review residents' drug regimes monthly. Staff will be re-educated regarding the use of psychoactive medications. Nursing leadership will complete one psychoactive medication audit each week until the April QA&A meeting on 4/16/13. The Director of Nursing will bring any identified audit concerns to the facility QA&A committee for review and further recommendations. The Director of Nursing remains responsible for compliance with this requirement to ensure that residents are free from any unnecessary drugs. See also F154. Completion date for certification purposes only:	4/9/13

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F 329	Continued From page 25 the plan of care. The care plan also lacked non-pharmacological interventions to implement prior to the PRN use of the Trazadone and Zyprexa, and lacked what kind of hallucinations R330 experienced. The medical record for R330 was reviewed on 2/28/13, at 11:00 a.m. R330 had target behaviors for monitoring the hallucinations (which were not identified as to the type of hallucinations R330 experienced) and the Trazadone had target behaviors for sleep. The medical record lacked evidence of the AIMS/DISCUS for abnormal body movements at baseline. The medication administration and treatment records for February 2013 for R330 were reviewed. Both records lacked monitoring for the side effects of the Trazadone and Zyprexa medications. An email interview from the pharmacist dated 2/28/13, at 1:05 p.m. identified the pharmacist gave the facility the following recommendations for R330 on 2/19/13. 1. Informed consent needed to be obtained for the Trazadone and Zyprexa which included the potential side effects. 2. Complete the Abnormal-Involuntary-Movement-Scale (AIMS)/Dyskinesia Identification System: Condensed User Scale (DISCUS) at baseline and should be done every six months to monitor abnormal movements. 3. Update the target behaviors for the Zyprexa. "Behaviors should be due to mania or psychoses, present a danger to resident or others, or cause inconsolable distress, significant decline in	F 329		

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F 329	Continued From page 26 function or difficulty receiving care." 4. Side effect monitoring which included somnolence, weight gain, dizziness, falls, and movement. 5. To identify and implement non-pharmacological interventions for behavior disturbances. 6. Clarify the indications for the PRN Zyprexa use as agitation was not an appropriate indication of use. 7. Complete the sleep assessment for monitoring at baseline and then quarterly thereafter. The facility policy for AIMS Evaluation dated 2/28/13, noted the facility will monitor involuntary movements for residents who received the antipsychotic medications. The policy directed the staff to complete the evaluation upon admit or prior to starting a resident on the medication. R330 had been in facility for 12 days after admission and the evaluation had not been completed. The pharmacist recommended the facility complete the AIMS on 2/19/13, and the facility had not completed the evaluation per the recommendation. Registered nurse (RN)-D was interviewed on 2/28/13, at 11:00 a.m. and RN-D verified and acknowledged R330's medical record lacked the side effects. On 2/28/13 at 12:00 a.m. the director of nursing was interviewed and she verified and acknowledged the staff was to obtain the AIMS upon admit and every months thereafter. She also acknowledged R330's AIMS monitoring could not be located. The DON revealed the facility was still building R330's plan of care.	F 329		

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to store, sanitize and prepare food under sanitary conditions. This had the potential to affect 136 of 136 residents who eat at the facility. Findings include: On 2/25/13, on 1:29 p.m. an initial kitchen tour was completed. Issues identified include: The walk in freezer thermometer read 25 degrees Fahrenheit (F). RD-A confirmed the finding. RD-A stated the refrigerator repair man was out today and finished working on the door gasket at approximately 11:30 a.m. A stack of beef patties located in the middle of the freezer on a middle shelf was malleable when checked for solidness. RD-A confirmed that. RD-A confirmed the repair company was called 2/24/13, and made it out on 2/25/13. RD-A stated the shift supervisor on duty on 2/24/13, monitored the temperature of food with a manual thermometer and instructed staff	F 371	St. Anthony Health Center procures food from sources approved or considered satisfactory by Federal, State or local authorities; and stores, prepares, and serves food under sanitary conditions. Although we disagree with the issuance of this tag, the following measures were initiated to continue compliance. The hamburger patties noted to have begun to thaw were immediately removed to ensure they would not be served to residents of St. Anthony Health Center. Staff continued to monitor the other items in the walk-in freezer to ensure they were frozen solid. The freezer has been serviced and is maintaining acceptable temperatures. Protocols related to freezer temperatures, sanitizing items in the three-compartment sink, and cutting food have been reviewed and revised. Kitchen staff have been educated on these protocols. The Director of Dietary Services or designee will conduct two kitchen sanitation audits per week. These audits will continue until the facility QA&A meeting on 4/16/13. The facility QA&A committee will review completed audit results and make further recommendations. The Director of Dietary Services is responsible for compliance with this requirement. Completion date for certification purposes only:	4/9/13

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F 371	Continued From page 28 not to open door unless needed. RD-A verified this was not documented. On 2/25/13, at 1:46 p.m. RD-A verified staff used the three compartment sink for sanitizing pots and pans. RD-A stated staff were not checking the chemical parts per million (ppm) to ensure the dishes were effectively sanitized. RD-A reported she kept the strips in her office. On 2/28/13, at 12:02 p.m. a follow up kitchen tour was completed. The walk-in in freezer thermometer read 15 degrees F. The Freezer and Refrigerator Temperatures log for 2/16/13 to 2/28/13 identified the freezer temperature was out of range on 13 of 13 days. It indicated the temperature should have been zero degrees F. The recorded temperatures ranged from 5 degrees F to 26 degrees F. RD-A confirmed the recorded temperatures were out of range. RD-A confirmed no other action had been taken to ensure the freezer kept foods at the proper temperature. On 2/28/13, at 12:16 p.m. cook (C)-A was being trained by cook (C)-B. Cook-A took a large ham roast and diced it with a knife on a food serving tray that was not made to cut on. RD-A stated the ham was being prepared for the Quiche Lorraine. RD-A reported staff were not supposed to use trays as a cutting surface. RD-A then requested C-A to use a cutting board. On 2/28/13, at 12:22 p.m. RD-A stated she contacted Ecolab, the facility's sanitizer distributor, on 2/25/13, after the initial kitchen tour. RD-A reported the Ecolab representative advised that staff should check the three	F 371		

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F 371	Continued From page 29 compartment sink's sanitizing compartment once every shift, for the ppm to ensure dishes were effectively sanitized. RD-A stated Dietary aide (DA)-A was washing dishes today. When asked where DA-A was to interview, RD-A stated DA-A would not know how to check the ppm as she was unable to train the staff on how to complete the test. RD-A confirmed the ppm was not checked this morning or this afternoon during dishes. RD-A stated staff do use the three compartment sink to sanitize pots/pans and miscellaneous dishes. On 2/28/13, at 12:27 p.m. kitchen supervisors (KS)-A reported the facility trained staff about a year ago about not cutting on fiberglass trays. KS-A stated he was aware of the issue and staff had been educated. Education documentation was requested at this time, no education documentation was provided. On 2/28/13, at 1:35 p.m. KS-A and dietary aide (DA)-A checked the three compartment sink Oasis 144 sanitizer concentration. KS-A and DA-A was asked to complete the test as they normally would at the start of doing dishes. KS-A and DA-A found a medium sized steam table pan and filled it about 3/4 full of water and sanitizer, in the sanitizing compartment of the three compartment sink. The test strip comparison sheet instructed staff to dip the test strip for 10 seconds. KS-A took the test strip and put it in the water for approximately five seconds. The test strip was dark green. KS-A compared it to the back of the test strip container which read approximately 400-500 ppm. KS-A was asked to retest the concentration. KS-A took a five inch strip of the litmus paper and submerged it in the	F 371		

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F 371	Continued From page 30 water for approximately eight seconds. KS-A compared the strip to the back of the testing area. KS-A stated that it has "plenty" of sanitizing solution as it read 400 ppm. DA-A confirmed it was more between 450-500 ppm. KS-A and DA-A reported they know this amount was "ok" because the Ecolab representative trained them that this was an okay range. KS-A and DA-A was not sure where to find a reference range for safe sanitizing concentration. KS-A and DA-A confirmed most pots and pans were sanitized through the dishwasher but that some large oven pans used to cook large amounts of ground beef and poultry were too big to fit in the dishwasher and needed to be sanitized in the three compartment sink with the chemical sanitizer. KS-A stated these large pans were sanitized in the medium sized steam table pan, even though the pan would not be fully submerged and would not fit in this pan. On 2/28/13, at 3:35 p.m. RD-A verified the facility did not have a policy for sanitizing dishes in the three compartment sink. RD-A was not sure what the ppm should be for the three compartment sink with the oasis 144. RD-A stated it did not make sense for the staff to fill the steam table holding pan in the sanitizing sink with water and sanitizer as the pans they sanitize in that sink would be much larger than the pan and would not be effectively sanitized. RD-A verified at this time a normal range for a freezer was zero or less. On 2/28/13, at 5:30 p.m. the Ecolab representative was called a message was left. On 3/11/13, at 7:00 p.m. Ecolab representative was called and message was left. Ecolab did not return the telephone calls.	F 371		

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F 371	Continued From page 31 Refrigerator and Freezer Temperature Policy dated 7/04, indicated daily temperature in each freezer was to be taken and recorded. It instructed if the temperature falls out of range of "normal," notify the department head for follow up. If the temperature remains out of the normal range, maintenance would be notified "ASAP [as soon as possible]." RD-A confirmed that was not done related to the freezer not maintaining temperature.	F 371		
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	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. Although we disagree with the issuance of this tag, the following measures were initiated to continue compliance. The facility's policy and procedure regarding Cleaning Glucometers has been reviewed and revised. Staff will be re-educated on the Cleaning Glucometers policy and procedure, and will need to demonstrate to the instructor that they can correctly perform the task. Nursing leadership will complete three glucometer cleaning audits per week until all nurses have been audited. The Director of Nursing will review completed audits and bring any identified concerns to the facility QA&A committee for further recommendations.	

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F 441	Continued From page 32 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure re-usable patient equipment was properly sanitized between resident (R) uses for 5 of 6 blood sugar tests observed. (R5, R334, R188, R284, R119, R168). Findings include: R5 had a diagnosis of diabetes and received blood sugar tests twice a day on Monday, Wednesday, and Friday, and did not have an infectious disease. On 2/27/13, at 7:09 a.m. licensed practical nurse (LPN)-A did a blood sugar for R5, setting the glucometer down on the counter top twice (without a barrier) in R5's room, took her gloves off then carried the used finger stick device (sharp) and glucometer back to the medication (med) cart. LPN-A then disposed of the sharp, put the glucometer back into the red bin, and then took R5 down to breakfast. LPN-A picked up the glucometer again, read the result, put the glucometer back in the red bin, and	F 441	The Director of Nursing remains responsible for compliance with this requirement to ensure a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. Completion date for certification purposes only:	4/9/13

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 33	F 441		

charted the result. The glucometer was not properly disinfected prior to being placed in the red bin; that action exposed the clean supplies in the red bin to blood borne pathogens.
LPN-A then took a Super Sani-cloth (a disinfecting wipe) out of the medication cart and cleaned the glucometer with the Super Sani-cloth by wiping it down for 10 seconds with the Super Sani-cloth and immediately put the next test strip, alcohol pad, and cotton 2x2 on top of the wet machine.
When asked if it contaminated the supplies in the red bin to put the un-cleaned glucometer back in the red bin, LPN-A stated, " Yes " (but did not destroy the supplies). When asked how long to wait after wiping the glucometer, LPN-A stated "5 seconds. " (Dry time was two minutes or more).
R284 had a diagnosis of diabetes and received blood sugar checks four times a day and did not have an infectious disease.
At 7:12 a.m. LPN-A carried the wet glucometer and contaminated supplies to R284's room, set the glucometer on the counter (without a barrier), checked the blood sugar, then put the glucometer back on the counter top (without a barrier), removed her gloves and carried the glucometer and sharp out to the med cart and put the glucometer on the med cart [without a barrier] charted the result, and disposed of the sharp.
R119 had a diagnosis of diabetes, received blood sugar checks twice a day and did not have an infectious disease. At 7:20 a.m. LPN-A cleaned the glucometer with the Super Sani-cloth, and immediately put the next test strip, alcohol pad, and cotton 2x2 on top of the wet machine for the next blood sugar test. LPN-A carried the wet glucometer and contaminated supplies to R119's room, set the glucometer down on the counter

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	245267	A. BUILDING _____ B. WING _____	02/28/2013

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 441	Continued From page 34 (without a barrier), checked the blood sugar, then put the glucometer back on the counter top (without a barrier), removed her gloves and carried the glucometer and sharp out, put it on the med cart (without a barrier), and charted the result. LPN-A disposed of the sharp. R168 had a diagnosis of diabetes, received a blood sugar check twice a day and did not have an infectious disease. At 7:23 a.m. LPN-A used a Super Sani-cloth to clean the glucometer and immediately put the next test strip, alcohol pad, and cotton 2x2 on top of the machine and carried the wet glucometer to R168's room. LPN-A set the glucometer down on the counter (without a barrier), checked the blood sugar, put the glucometer back on the counter top (without a barrier), removed her gloves, carried the glucometer and sharp out and put it on the med cart (without a barrier), charted the result and disposed of the sharp. R334 had a diagnosis of diabetes, received a blood sugar check twice a day and did not have an infectious disease. At 7:26 a.m. R334 was taken into the (un-occupied) tub room. LPN-A then returned to the med cart, used a Super Sani-cloth to clean the glucometer and immediately put the next test strip, alcohol pad, and cotton 2x2 on top of the machine and carried the wet glucometer to the tub room. LPN-A set the glucometer down on the tile half wall in the tub room (without a barrier), used an alcohol wipe to clean R334's finger and then used a waving motion to dry the alcohol . LPN-A then checked the blood sugar, put the glucometer back on the tile half wall (without a barrier), removed her gloves and carried the glucometer and sharp out and put it on the med cart (without a barrier). LPN-A disposed of the sharp and then charted	F 441		

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F 441	Continued From page 35 the result. The un-sanitized glucometer was left sitting on top of the med cart for 30 minutes. R188 had a diagnosis of diabetes, received blood sugar check twice a day and did not have an infectious disease. At 8:04 a.m. LPN-A used a Super Sani-cloth to clean the glucometer and immediately put the next test strip, alcohol pad, and cotton 2x2 on top of the machine and carried the wet glucometer to R188's room , LPN-A put the glucometer down on the over bed table (without a barrier). Used the alcohol pad to clean R188 ' s finger and then used a waving motion to dry the alcohol. LPN-A checked the blood sugar, set the glucometer on the over bed table (without a barrier), took off her gloves and carried the sharp and glucometer out and set them down on top of the med cart (without a barrier). LPN-A disposed of the sharp and charted the result. The un-disinfected glucometer was left sitting on the med cart. On 2/27/13, at 8:30 a.m. the glucometer still had not been cleaned, LPN-A stated she "always cleaned the glucometer just before she used it, but thinks the policy says to clean the glucometer after use as well." LPN-A stated she did not know you could not wave the finger dry after using an alcohol swab, and "did not know that the disinfecting wipe required a two minute wet time on the glucometer and was then supposed to air dry to ensure that blood borne pathogens were not transferred between residents." On 2/27/13, at 8:35 a.m. RN-C stated there was one glucometer for each hall, the machine was to be wiped down after each use. RN-C stated "the process was to take the glucometer to do the blood sugar check, put the barrier (a paper towel) down on the surface (counter top or over bed table), complete the blood sugar test and return	F 441		

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F 441	Continued From page 36 to the med cart, setting down the barrier (on top of the med cart)." Wipe down the glucometer with the Super Sani-cloth, RN-C correctly stated the glucometer must be visibly wet for 2 minutes and then air dry. On 2/28/13, at 12:08 p.m. the DON, stated the facility provides an annual training on glucometer devices and in addition had just completed a training with the new glucometer and new disinfecting wipe a couple of months ago. The DON would expect them to know the policy and how to use the wipes. The Centers for Disease Control (CDC) "Diabetes and Viral hepatitis" last updated 7/31/12, recommended Infection-Control and Safe Injection Practices to Prevent Patient to Patient Transmission of Blood borne Pathogens indicated: "Dispose of used finger-stick devices at the point of use in an approved sharps container, glucometers should be cleaned and disinfected between patient uses. Maintain supplies and equipment such as finger-stick devices and glucometers within individual patient rooms if possible. Have staff demonstrate knowledge of standard precautions guidelines and proficiency in application of these guidelines during procedures that involve possible blood or body fluid exposures." The (undated) facility policy Cleaning of Glucometers indicated, "Glucometers are to be disinfected with Gluc-Chlor or PDI Sani-cloth per the manufactures instructions, between resident uses as a prevention infection control measure." The (undated) manufactures instructions for PDI Super Sani-cloth indicated, "The treated surface	F 441		

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F 441	Continued From page 37 must remain visibly wet for a full two minute wet contact time. Let air dry." The facility policy lacked clear direction for the two minute disinfecting wet time recommended by the manufacturer and by CDC.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a clean and sanitary environment for 3 of 4 upholstered chairs. This had the potential to affect all 14 residents and visitors of the memory care unit. Findings include: On 2/28/13, at 3:20 p.m. there were four green colored upholstered chairs located on the locked memory care unit near the nursing station. Three of the four chairs arm rests were observed. The armrests on three of four chairs were torn and had exposed white stuffing coming out from the torn areas. Also, the seat cushions where the areas curved around the bottom of the arm rests were torn and white stuffing was noted to be coming out from those areas. One resident was observed to be seated in one of the torn upholstered chairs. The chairs were uncleanable.	F 465	St. Anthony Health Center provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Although we disagree with the issuance of this tag, the following measures were initiated to continue compliance. The frayed chairs were immediately removed from the facility. Replacement chairs have been ordered. A few dining room chairs have been relocated to the lounge to ensure adequate seating until the new chairs arrive. Facility furniture has been inspected and no additional uncleanable surfaces have been identified. Policies and procedures regarding maintenance requests/work orders, as well as the environmental rounds audit form and schedule have been reviewed and revised as appropriate. Staff will be inserviced regarding reporting maintenance needs/work orders. The Director of Environmental Services or designee will conduct one environmental rounds audit per week. These audits will continue until the facility QA&A meeting on 4/16/13.	

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F 465	Continued From page 38 When interviewed on 2/28/13, at 3:20 p.m. registered nurse-A verified the three chairs arm rests exposed the white stuffing which rendered the chairs uncleanable. When asked for a maintenace	F 465	The facility QA&A committee will review completed audit results and make further recommendations. The Director of Environmental Services is responsible for compliance with this requirement. Completion date for certification purposes only:	4/9/13

F 526 7021

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

PRINTED: 03/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2013

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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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on February 27, 2013. At the time of this survey, St. Anthony Health Center 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 (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and, Marian.Whitney@state.mn.us	K 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. POC ok TB 3-27-13	

DC: 04.09.2013
EXIT: 02.28.2013

RECEIVED
MAR 25 2013
DIVISION OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marian Lindsey, Executive Director
TITLE
(X6) DATE: 3/25/13

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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K 000	Continued From page 1	K 000		

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.

St. Anthony Health Center is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1997, an addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building.

The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 140 beds and had a census of 138 at the time of the survey.

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K 000	Continued From page 2 A K-067 has been written in past surveys. upon further detailed investigation it has been found that The supply and return for the 1967 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on documentation review, the facility fire safety plan did not meet all the requirements in accordance with NFPA 101 LSC (00), Section 19.7.1.1, 19.7.2.2. This deficient practice could affect all 140 residents, visitors, and staff in the event of an fire evacuation. Findings include: On facility tour between 12:30 PM and 3:30 PM on 02/27/13, a review of documentation revealed that the facility's fire safety plan did not address "Compartmental evacuation", as outlined in Section 19.7.1.1, 19.7.2.2. This was confirmed by the Maintenance Supervisor.	K 048	St. Anthony Health Center has a written plan for the protection of all residents and for their evacuation in the event of an emergency. Although we disagree with the issuance of this tag, the following measures were initiated to continue compliance. The facility fire safety plan has been reviewed and revised as appropriate. Staff will be inserviced regarding the fire safety plan. The Director of Maintenance or designee will conduct three fire safety plan awareness audits per week. These audits will continue until the facility QA&A meeting on 4/16/13. The facility QA&A committee will review completed audit results and make further recommendations. The Director of Maintenance is responsible for compliance with this requirement. Completion date for recertification purposes only:	4/9/13
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 050	St. Anthony Health Center holds fire drills as required by regulation. Although we	

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K 050	Continued From page 3 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports and records, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 140 residents, visitors and staff. Findings include: On facility tour between 12:30 PM and 3:30 PM on 02/27/13, a review of the available fire drill reports revealed that the facility's Day-shift fire drills in 2012 and 2013 were conducted between the hours of 1:13 PM, 9:10 AM, 12:58 PM, 9:32 AM, and the Night-shift fire drills between 5:05 AM, 4:35 AM, 4:50 AM, 4:45 AM not at varied times as required by Section 19.7.1.2. This deficient practice was confirmed by the facility Maintenance Supervisor.	K 050	disagree with the issuance of this tag, the following measures were initiated to continue compliance. The protocols for holding fire drills have been reviewed and revised as appropriate. A confidential scheduling plan has been developed. The facility QA&A committee will review fire drill times monthly and make further recommendations. The Director of Maintenance is responsible for compliance with this requirement. Completion date for recertification purposes only:	4/9/13
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052	St. Anthony Health Center has installed,	

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K 052 SS=F	Continued From page 4 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation smoke detectors were located within 36 inches of HVAC deflectors on the 2nd floor area. This deficient practice could effect all 140 building occupants in the event of a fire emergency and cause delay of the fire alarm activation in accordance with NFPA 70(99) and NFPA 72(99) edition. 9.6.1.4. Findings include: On facility tour between 12:30 PM and 3:30 PM on 02/27/2013, it was observed that 4 smoke detectors located by each of the 4 smoke barrier doors were located within 36 inches of the HVAC deflectors (supply and or return) not in accordance with NFPA 72 (99) edition. This deficient practice was confirmed by the facility Maintenance Supervisor.	K 052	maintains, and routinely tests a fire alarm system as required by regulation. Although we disagree with the issuance of this tag, the following measures were initiated to continue compliance. The four smoke detectors identified have been moved. The Director of Maintenance is responsible for compliance with this requirement. Completion date for recertification purposes only:	4/9/13