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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Z6TX
Facility ID: 00997

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245063**

2. STATE VENDOR OR MEDICAID NO. (L2) **491343400**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/28/2015** (L34)

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	

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 12/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/04/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 01/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/09/2015
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245063
January 12, 2016

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

Dear Mr. Barker:

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

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

Effective December 6, 2015 the above facility is certified for or recommended for:

84 Skilled Nursing Facility/Nursing Facility Beds

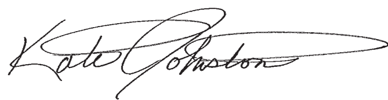
Your facility's Medicare approved area consists of all 84 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 12, 2016

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

RE: Project Number S5063026

Dear Mr. Barker:

On November 19, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 5, 2015. 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 December 28, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 7, 2015 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 November 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 5, 2015, effective December 6, 2015 and therefore remedies outlined in our letter to you dated November 19, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245063	A. Building B. Wing	12/28/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	**12/06/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	**12/06/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**12/06/2015**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**12/06/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**12/06/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/KJ	01/12/2016	16022	12/28/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/5/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245063	A. Building B. Wing 01 - MAIN BUILDING 01	12/7/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0054	11/26/2015	ID Prefix Reg. # NFPA 101 LSC K0074	12/06/2015	ID Prefix Reg. # NFPA 101 LSC K0144	11/26/2015
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	Date:	Signature of Surveyor:	Date:
	TL/KJ	01/12/2016	19251	12/07/2015
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
11/5/2015	

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Z6TX
Facility ID: 00997

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245063**

2. STATE VENDOR OR MEDICAID NO.
(L2) **491343400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/05/2015** (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
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 12/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/04/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 12/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 19, 2015

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

RE: Project Number S5063026

Dear Mr. Barker:

On November 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 15, 2015, 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 December 15, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 5, 2016 (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 May 5, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by

the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING ______ B. WING ______	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were within reach for 1 of 35 (R102) residents observed during stage I of the survey; and for 1 of 27 residents (R65) during an environmental tour on 11/34/15. Findings include: At 6:00 p.m. on 11/2/15, R102's call light was	F 246	St. Anthony Park Home will ensure that resident's 102 and 65, in addition to all other residents, have their call lights within reach when staff is not in the room. NAR's and nurses will be in serviced regarding the requirements of this tag. Nurses will monitor compliance with this tag on every shift. Nursing administration will conduct a tour of the residents room's one time per shift, five days each week to	12/6/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/25/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING ______ B. WING ______	11/05/2015

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

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F 246	Continued From page 1 noted to be on the floor, between the wall and the bed, which was up against the wall. R102 was capable of using the call light and during an interview at 5:15 p.m. on 11/2/15, was able to verbalize what the call light was for and how it was to be used. During an environment tour with the maintenance and housekeeping directors, starting at 10:37 a.m. on 11/4/15, R65's call light was noted to be on the floor behind R65's bed. R65 was in bed and when interviewed at this time, was able to accurately verbalize and demonstrate how to use the call light and when they would use the call light. At 1:52 p.m. on 11/04/15, the director of nurses stated there was an expectation that call lights be within reach of the resident. An undated policy titled Call Light indicated staff were to ensure the call light was within resident reach before leaving a resident's room.	F 246	ensure compliance. The DON will receive a report regarding the monitoring on a daily basis. The QA committee will review the monitoring results.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		11/26/15

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F 278	Continued From page 2 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R4) reviewed for the Preadmission Screening and Resident Review (PASRR) was accurately coded on annual Minimum Data Set (MDS) assessment. Findings include: R4's annual MDS, dated 10/15/15, did not identify R4 was diagnosed with mild cognitive impairment. The PASRR section A1500 was coded as "0" indicating this condition did not exist and therefore, the section A1510, level II PASRR conditions were not completed on the MDS. The admission record review iidentified R4 was re-admitted on 05/27/1990 with diagnoses that included mild intellectual disabilities, the PASRR screening was conducted on 11/15/14 by the county and indicated R4 had the condition of	F 278	St. Anthony Park Home will ensure that MDS's are coded correctly regarding a resident's level 2 PASRR status. Resident 39's MDS has been amended and re submitted. The MDS of the other resident who is a level two will be monitored for accuracy as will any additional residents admitted under the same circumstances. The MDS director will monitor each resident's annual MDS for compliance. The DON will receive a quarterly report from the MDS director regarding the results. The QA committee will review the monitoring.	

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F 278	Continued From page 3 intellectual disabilities and a level II PASRR was completed; however, the MDS dated, 10/15/15 did not reflect this. On 11/03/15 at 4:05 p.m. registered nurse (RN)-C stated the MDS was not coded accurately to reflect R4's mild intellectual disabilities and the need for PASRR. RN-C explained this needed follow-up and would modify and submit the corrected MDS.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 279	The Comprehensive care plan for	12/6/15

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F 279	Continued From page 4 facility did not ensure that information was addressed on the comprehensive plan of care to direct staff regarding urinary incontinence for 1 of 2 residents (R5) with urinary incontinence, to direct staff of interventions to help minimize irritability for 1 of 5 (R39) residents who was on an antidepressant medication, to direct staff in measures to minimize the risk for bruising for 1 of 5 residents (R102) on an anticoagulation medication and failed to direct staff in regards to shaving for 1 of 1 resident (R56) who required assist with facial hair removal. Findings include: Discharged resident R5's initial Minimum Data Set (MDS) dated 7/5/15, identified R5 was frequently incontinent of urine. A quarterly MDS dated 10/3/15, revealed R5's level of urinary incontinence had decreased to always being incontinent. The Care Area Assessment (CAA) Summary dated 7/7/15, directed to proceed to care planning for urinary incontinence. However, the care plan was not developed to address this triggered area. At 10:36 a.m. on 11/04/15, the care plan dated 10/15, was reviewed with the director of nurses (DON.) When asked if there was information regarding R5's urinary incontinence the DON stated "I wish I could find it." R39's care plan was not developed to address R39's mood symptoms or direct staff with interventions to minimize R39's irritabilty. A review of admission orders revealed that at the time of admission, 9/10/14, R39 was not taking an antidepressant medication. On 2/7/15, Celexa	F 279	resident R39 has been updated to address mood symptoms and use of antidepressant medication. Comprehensive care plan for resident R102 has been updated to reflect potential for bruising and measures to minimize the risk of bruising related to use of anticoagulant medication. Comprehensive care plan for resident R56 has been updated to reflect need for assist with grooming and shaving, including resident’s shaving preferences. Resident R5 is deceased so care plan has not been modified. All care plans will be monitored quarterly by QA in conjunction with the quarterly MDS for accuracy. Nursing administration will monitor each care plan each quarter to ensure accuracy. The results of the monitoring will be reviewed by the QA committee.	

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F 279	Continued From page 5 (antidepressant) 10 milligrams (mg) every day was orderd by the nurse practitioner due to R39's outbursts, agitation, bossiness, intrusiveness, not responding to redirection and increased irritability/aggression/verbal abuse towards staff and other residents. During interview, registered nurse (RN)-A stated, at 7:17 a.m. on 11/4/15, the care plan did not always cover the specific mood signs, because mood signs were covered in the monthly mood notes. RN-A stated R39 was "certainly irritable" and that this was R39's main mood sign. At 7:30 a.m. R39's, 3/18/15, care plan was reviewed with RN-A. When asked if the care plan directed staff of non pharmacological interventions to minimize R39's irritability and use of an antidepressant medication, RN-A stated "No, it doesn't." R102 was admitted to the facility on 5/7/15, with physician orders for the anticoagulant Coumadin and review of the most recent physician orders dated 10/15, revealed R102 has remained on the Coumadin. The care plan was not developed to address R102's potential risk for bleeding/bruising and did not direct staff of interventions to minimize this risk. During interview, at 7:32 a.m. on 11/4/15, R102's care plan, dated 8/10/15, was reviewed with RN-A. When asked if the care directed staff of measures to minimize the risk for bruising, due to anticoagulant use, RN-A stated "No, it doesn't." R56 was observed to have several facial hairs the morning and afternoon of 11/3/15, and during the day on 11/4/15. R56 care plan lacked interventions regarding	F 279		

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F 279	Continued From page 6	F 279		

shaving.

R56's clinical record noted R56 was admitted to the facility on 7/24/09. R56's quarterly Minimum Data Set (MDS) dated 9/6/15, identified R56 required extensive to total assist with bed mobility, transfers, dressing, toileting and personal hygiene needs.

The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 3/25/15, indicated, "Resident requires physical staff assist of 1-2 in all aspects of ADL's. Resident participation with ADL's has declined..."

The care plan revision goal dated 1/31/15, identified R56 had alteration in ADL's and directed staff: Goal; The resident will maintain current level of function in ADL's and feeding through the review date. Interventions... Oral care routine: requires extensive assist of 1 to brush teeth and rinse mouth, however the care plan did not address shaving facial hair for the resident.

On 11/3/15 at 9:38 a.m., 11:21 a.m. and 2:35 p.m. R56 was observed to have several gray/white facial hairs to the upper lip and the chin area.

On 11/4/15 at 9:44 a.m. R56 was observed in his room lying in bed and was observed to still have numerous facial hairs. At 10:05 a.m. resident was able to communicate that he needed to be shaved by a staff member.

During an interview with licensed practical nurse (LPN)-A on 11/3/15 at 3:35 p.m. LPN-A stated, resident requires extensive to total assist with all ADLs.

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F 279	Continued From page 7 During an interview on 11/3/15 at 3:56 p.m. with nursing assistant (NA)-B, stated, resident requires total assist with shaving. During an interview on 11/4/15 at 10:24 a.m., director of nursing (DON) verified, the care plan did not address shaving for R56. An undated policy and procedure titled RESIDENT CARE PLANNING, indicated, "Policy statement: Each resident has a resident care plan that is current, individualized, and consistent with the medical regimen. Policy: 3. Following interdisciplinary team conference, which occurs 21 days after admission, and every 90 day thereafter, the nurse coordinates the resident care plan for all disciplines by updating goals and actions that were discussed." The The Procedure identified that care plans are reviewed quarterly, upon significant change and as needed for changes/updates with resident needs/plan of care.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		12/8/15

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F 280	Continued From page 8 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise a care plan for 1 of 3 residents (R100) for meal assistance. Findings include: R100's care plan was not revised after a quarterly minimum data set was completed. The resident's plan of care, revised 8/11/15, identified R100 was able to feed self after a tray was set up. R100's quarterly MDS assessment dated 10/14/15, identified R100 required extensive assist with eating. On 11/4/15, the resident was observed sleeping in bed from 7:13 a.m. to 10:12 a.m. There were glasses of fluid and a cheese like snack food at the bedside. At 1:32 p.m. the resident reported she didn't have much of an appetite, and did not eat much. The resident's husband reported R100 does go to the dining room on occasion for meals, but doesn't eat very much. On 11/4/15 at 9:33 a.m., the nursing assistant (NA)-A reported R100 did not want to eat today even after much coaxing, but does go down to the dining room on occasion. NA-A indicated staff open cartons, pour beverages and cut up food for R100. NA-A reported R100 was able to feed self	F 280	The Comprehensive care plan for resident R100 has been updated to reflect the need for assist with feeding. All care plans will be monitored by Nursing Administration with each status change and when an MDS is due. The DON will receive a report of the monitoring each week. The QA committee will review the results at the quarterly meeting.	

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F 280	Continued From page 9 after tray set up. On 11/04/15 at 2:20 p.m. registered nurse (RN)-B indicated that during the quarterly assessment period R100 needed extensive assist with eating and agreed the care plan had not been updated or revised to direct staff that the resident required extensive supervision and assist. An undated policy and procedure titled RESIDENT CARE PLANNING, indicated, "Policy statement: Each resident has a resident care plan that is current, individualized, and consistent with the medical regimen. Policy: 3. Following interdisciplinary team conference, which occur 21 days after admission, and every 90 day thereafter, the nurse coordinates the resident care plan for all disciplines by updating goals and actions that were discussed. Procedures: a. Care plans are reviewed quarterly, upon significand (significant) change and as needed for changes/updates with resident needs/plan of care."	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal hygiene care for 1 of 1 resident (R56) who was dependent on staff for personal cares.	F 312	The staff will ensure that all male residents will be shaved daily or according to their preference as identified in their plan of care. The comprehensive care	12/6/15

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F 312	Continued From page 10 Findings include: R56 was observed to have several facial hairs the morning and afternoon of 11/3/15, and during day on 11/4/15. R56's clinical record noted R56 was admitted to facility on 7/24/09, and had diagnoses, which included Parkinson's disease, dementia, cervicalgia and hypertension. Medication that included, Aricept, Metoprolol, Norvasc and Carbidopa-levodopa. R56's quarterly Minimum Data Set (MDS) dated 9/6/15, identified R56 required extensive to total assist with bed mobility, transfers, dressing, toileting and personal hygiene needs. The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 3/25/15, indicated, "Resident requires physical staff assist of 1-2 in all aspects of ADL's. Resident participation with ADL's has declined..." The care plan revision goal dated 1/31/15, identified R56 had alteration in ADL's and directed staff, " The resident has an ADL self-care performance deficit r/t (relate to) dx (disease): Dementia/Lewy Bodies, hx (history) of CVA (cardiovascular disease). Goal: The resident will maintain current level of function in ADL's & (and) feeding through the review date. Interventions ... Oral care routine: requires extensive assist of 1 to brush teeth and rinse mouth." However the care plan did not address shaving facial hair for resident.	F 312	plan for resident R56 has been updated to reflect need for assist with grooming and shaving, including resident's shaving preferences. All nursing staff will be trained on this requirement. Nurses will monitor for compliance on a daily basis. Nursing Administration will check with each resident four times a week to ensure the resident is being shaved as requested. The QA committee will review the results at the quarterly QA	

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F 312	Continued From page 11 On 11/3/15 at 9:38 a.m., 11:21 a.m. and 2:35 p.m. during an attempt to interview R56, he was observed to have several gray/white facial hairs to the upper lip and the chin area. On 11/4/15 at 9:44 a.m. R56 was observed in his room lying in bed and was observed to still have numerous facial hairs. Resident was able to communicate his need to be shaven by a staff member. During an interview with licensed practical nurse (LPN)-A on 11/3/15 at 3:35 p.m. LPN-A stated, resident requires extensive to total assist with all ADLs. During an interview on 11/3/15 at 3:56 p.m. with nursing assistant (NA)-B, stated, resident requires total assist with shaving. During an interview on 11/4/15 at 10:24 a.m., director of nursing (DON) verified R56 was unshaven. An undated policy and procedure titled SHAVING THE MALE RESIDENT, Policy Statement directed staff, "To keep the male's face clean and free to beard."	F 312		

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

F5063024

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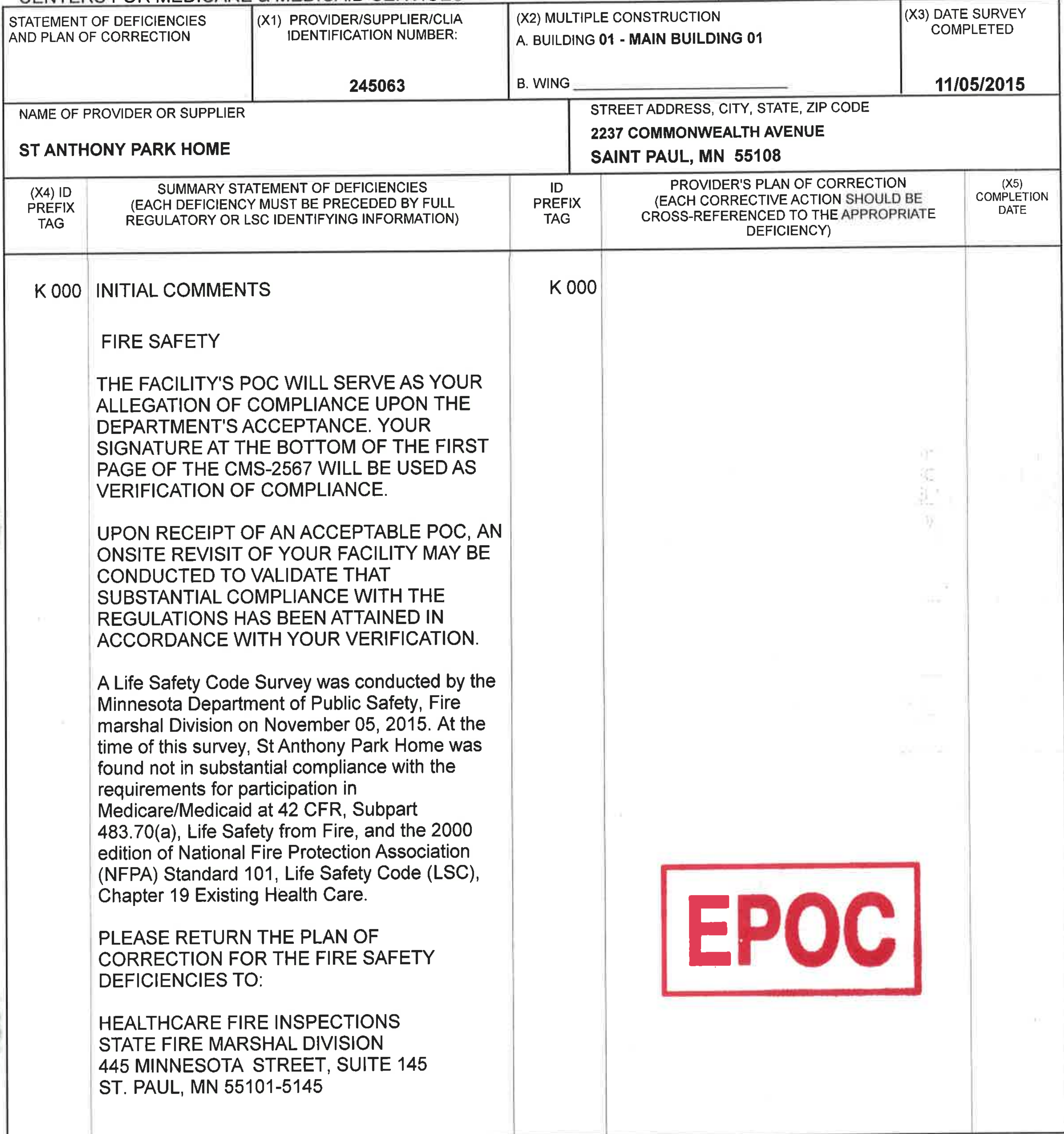
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/05/2015

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ST ANTHONY PARK HOME	2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on November 05, 2015. At the time of this survey, St Anthony Park Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 11/25/2015

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/05/2015**

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

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K 000	Continued From page 2 in all the sleeping rooms of the 1999 additions. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code. The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 81 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 1:00 PM and 4:00 PM on 11/05/2015, a review of the facility's available fire alarm test documentation revealed that the facility failed to conducted the required sensitivity test of each smoke detector, the last smoke detector	K 054	Sensitivity testing was completed on the required smoke detectors on November 12, 2015. The Maintenance director will schedule the required testing each year. The Administrator will monitor for compliance each year.	11/26/15

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K 054	Continued From page 3 sensitivity test was conducted in 4/01/2013 with some detectors failing. This was confirmed by the Maintenance Supervisor.	K 054		
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has cubicle curtains that does not meet the requirements in accordance with NFPA 25 (98) and NFPA 701 (99). This deficient practice could affect all residents, staff and visitors by hampering proper sprinkler coverage.	K 074	The cubical curtains in room 208 and 212 have been received (as of today November 25, 2015) and will be installed by December 1, 2015. All other curtains not in compliance have also been received. Our order was actually placed	12/6/15

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K 074	Continued From page 4 Findings include: On facility tour between 1:00 PM and 4:00 PM on 11/05/2015, it was found that the cubicle curtain in resident rooms 108 and 112 did not meet the 18 inch mesh requirement in accordance with NFPA 25 (98) and NFPA 701. This was confirmed by the Maintenance Supervisor.	K 074	in late October, before our survey. The maintenance director and the housekeeping director will monitor the cubicle curtains on a quarterly basis to ensure on going compliance with this tag. The administrator will receive the quarterly report regarding their findings.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 1:00 PM and 4:00 PM on 11/05/2015, based on review of available documentation it was revealed that there was no	K 144	St. Anthony Park Home has been in compliance with tag K144 the entire year. The generator was load bank tested on November 24, 2014 but the facility did not understand what the Fire Marshall was asking for during the survey therefore the report was not given to him. By the time the administrator contacted the fire Marshall, one week after the survey, the survey had already been submitted to the health department. The generator was tested again on	11/26/15

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K 144	Continued From page 5 documentation that the generator had not been tested under load in the past year. This deficient practice was verified by Maintenance Supervisor.	K 144	November 23, 2015 and therefore the facility will be in compliance with this tag for another 366 days (leap year is next year).	