Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 2, 2026

Administrator
St Anthony Health & Rehabilitation
3700 FOSS ROAD NORTHEAST
ST ANTHONY, MN 55421

RE: CCN:245267
Cycle Start Date: June 18, 2026

Dear Administrator:

On June 18, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 September 18, 2026 (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).

In addition, if substantial compliance with the regulations is not verified by December 18, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HEALTH & REHABILITATION	3700 FOSS ROAD NORTHEAST , ST ANTHONY, Minnesota, 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
E0000	Initial Comments On 6/15/26 through 6/18/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E0000		07/02/2026
F0000	INITIAL COMMENTS On 6/15/26 through 6/18/26, a standard recertification survey (S#5267042) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52672877C (iQIES #3005341), H52672878C (iQIES #2998222), H52672879C (iQIES #2694982). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		07/02/2026

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 reverse for further 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.

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

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F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	F880 – Infection Control Facility immediately educated laundry personnel to ensure proper usage of personal protective equipment (PPE) while sorting soiled linens and personal laundry. Appropriate PPE was placed and stored in the laundry area. All residents have the potential to be affected by the deficient practice. Laundry staff were educated on proper usage of PPE while sorting soiled linens and personal laundry. The facility will audit staff 3 times per week to ensure proper usage of PPE while sorting soiled lines and personal laundry for 4 weeks, then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Environmental Services Manager and/or Designee will be responsible party.	07/28/2026

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F0880 SS = F	Continued from page 2 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews, the facility failed to ensure proper usage of personal protective equipment (PPE) while sorting soiled linens and personal laundry. This had the potential to affect all 92 residents residing in the facility. Findings include: During tour of the laundry room on 6/16/26 at 3:17p.m. no PPE was observed anywhere in the dirty linen sorting area. On 6/16/26 at 3:17 p.m. housekeeping supervisor (HS) confirmed staff do not wear the required PPE while sorting soiled laundry. HS stated they will wear gloves but no other items. This had been the practice since they started working in the laundry room the previous year. On 6/16/26 at 3:09 p.m. administrator stated their expectation was staff wore full PPE, including gown, gloves, and goggles while sorting laundry. On 6/16/26 at 3:47 p.m. administrator stated the facility did not have a laundry policy.	F0880		07/28/2026

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F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure privacy for 1 of 1 resident (R101) reviewed for dignity. Findings include: R101 face sheet indicated admission on 6/9/26, diagnoses included Urinary	F0550	F550 – Resident Rights/Exercise of Rights R101 was discharged from the facility on 6/25/2026. Facility completed audit on all residents with a urinary catheter bag to ensure urinary catheter bag was covered to ensure resident dignity. Staff education was initiated to ensure privacy specific to dignity of covering the urinary catheter bag. The facility will audit 3 residents per week to ensure urinary catheter bag is covered for 4 weeks then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	07/28/2026

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F0550 SS = D	Continued from page 4 Tract Infection, Neuromuscular dysfunction of the bladder, Infection and inflammatory reaction due to indwelling urethral catheter. During observation on 6/17/26 at 10:29 a.m. R101 was ambulating with occupational therapist (OT)-A. An uncovered urinary catheter bag was hanging on the lowest bar of the wheeled walker. R101 and OT-A ambulated down the hallway, past the nurse's station and dining room, to the end of another hall before he sat down to rest. R101 walked past 2 staff and 2 residents. During interview on 6/17/26 at 10:40 a.m. OT-A stated she forgot to move the privacy bag with the catheter bag to the walker. She stated catheter bags should remained covered for resident's privacy. During interview on 6/17/26 at 1:20 p.m. R101 stated preference to have catheter bag covered when in public areas. During interview on 6/17/26 at 1:25 p.m. registered nurse (RN)-A stated catheter bags were to be covered. "It's a dignity issue". A catheter policy was requested; however, none was provided.	F0550		07/28/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to follow standards of practice for medication management for 1 of 8 residents (R72) reviewed for medication administration. Findings include: During a medication administration observation on 6/16/26 at 5:20 p.m., it was noted R72's order in the facility's electronic medication administration record (EMAR) indicated R72's Morphine Sulfate order was dispensed as 15 milligram (MG) tablet (TAB) with a dose of 2.5mg to be given sublingually (under the tongue) every (q) 3 hours. However, the Morphine sulfate card from the pharmacy showed the medication was a 2.5mg sublingual tablet to be given q6hrs. Registered nurse (RN)-A confirmed they	F0684	F684 – Quality of Care R72 order and dispensed medication card were corrected to ensure the order and card match. Facility completed audit of all residents with morphine orders to ensure order and dispensed medication card match. The facilities Medication and Treatment Orders policy was reviewed and remains current. Licensed Nurse, TMA and HUC education was initiated to ensure orders are appropriate transcribed and match the dispensed medication card. The facility will audit 3 residents with Morphine orders per week to ensure order and dispensed medication card match for 4 weeks, then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	07/28/2026

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F0684 SS = D	Continued from page 5 did not match and tended to happen with sublingual tablet orders. R72's annual minimum data set (MDS) dated 4/14/26, indicated R72 was admitted 4/1/26, severely cognitively impaired, and had the following diagnoses: atrial fibrillation (top two chambers of the heart don't pump correctly), coronary artery disease, heart failure, hypertension (high blood pressure), diabetes, Alzheimer's, anxiety, arthritis, and non-Alzheimer's dementia. R72's order summary report printed 6/16/26, indicated R72 had a current order for Morphine Sulfate 15mg tablet- give 2.5mg sublingually q3hr for pain. R72's [provider] Hospice physician orders form dated 6/12/26, indicated the handwritten order from the provider: Morphine 2.5mg solutab: give 1 solutab under the tongue every 3 hours for pain. R72's current medication cards read as follows: -Card #1(lableled #15)-Morphine Sulfate 2.5mg sol tab- 1 tablet orally or sublingually every 6 hours: 1 tablet orally or sublingually every hour as needed. There were no dose change stickers on the card. -Card #2-(lableled #16)-Morphine Sulfate 2.5mg sol tab- 1 tablet orally or sublingually every 6 hours: 1 tablet orally or sublingually every hour as needed. There were no dose change stickers on the card -Care #3-(lableled #17)-Morphine Sulfate 2.5mg sol tab- 1 tablet orally or sublingually every 6 hours: 1 tablet orally or sublingually every hour as needed. There were no dose change stickers on the card On 6/16/26 at 5:20p.m. RN-A confirmed they failed to follow the 5 rights of medication administration, 1-Right person, 2-Right Drug, 3-Right Dose, 4-Right Route, 5-Right time. RN-A confirmed the dose of the tablet and the time on the cards did not match the current order, but as the dose was the same, they continued to use the card. RN-A stated they would normally call the pharmacy and get a card with the correct information sent over, but they had not done that as the dose had matched. Furthermore, RN-A stated they had stickers they can put on the card to alert other staff members to the change in dose, however they had not used the sticker, because they had forgotten. On 6/18/26 at 0910 a.m., pharmacist (PHRM) confirmed R72's orders had a tablet strength of	F0684		07/28/2026

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F0684 SS = D	Continued from page 6 15mg listed. They stated the wrong dose had most likely been selected when ordering the tablet. PHRM stated they attempted to catch transcription errors during monthly medication review; however, this one had been missed. Their expectation was the cards and the orders matched. It was important to ensure to prevent medication error or overdose. On 6/18/26 at 9:43 a.m. director of nursing (DON) stated the process and expectation for transcribing orders was the order would be written by the provider, given to the health unit coordinator (HUC) to be entered, then reviewed by two nurses to verify the orders. The DON confirmed R72's had been confirmed by two nurses. However, the orders did not match, and they expected staff to have been using the order/dose change sticker. The DON stated the importance of verifying orders were transcribed correctly and the staff were using the 5 rights of medication administration to ensure they provided medications safely and don't have the wrong dose. The facility medication and treatment orders policy dated January 2024, indicated orders for medications and treatments will be transcribed accurately and in a timely manner. Orders must include the following: A: Name and strength of drug B: Number of Doses, start and stop date, and/or specific duration of therapy C: Dosage and frequency of administration D: Route of administration E: Clinical Condition or symptoms for which the medication is prescribed F: Any interim follow-up requirements	F0684		07/28/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F0756	F756 – Drug Regimen Review R13 pharmacy recommendation was addressed with medication order adjusted per pharmacy recommendation. Facility completed audit of all pharmacy recommendations of current residents for the months of March, April, May and June 2026 to ensure recommendations were appropriately addressed and completed. The facilities Consultant Pharmacist Report policy was reviewed and remains current.	07/28/2026

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F0756 SS = D	Continued from page 7 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview the facility failed to ensure pharmacy recommendations were addressed for 1 of 5 residents (R13) reviewed for unnecessary medications. Findings include: R13's quarterly minimum data set (MDS) dated 4/2/26, indicated R13 was admitted 2/25/26, severely cognitively impaired, and had the following diagnoses: hypertension (HTN) (high blood pressure), renal insufficiency, diabetes, thyroid disorder, non-Alzheimer's dementia, and a stroke. R13's Clinical physician orders printed 6/17/26, indicated R13 was currently prescribed the following HTN medications: Metoprolol Succinate extended release (ER)-50	F0756	Continued from page 7 Clinical Managers were educated on the monthly pharmacy recommendation process including ensuring all pharmacy recommendations are reviewed and completed per recommendation. The facility will audit 10 pharmacy recommendations per month to ensure recommendation was reviewed and completed per recommendation for 4 months, then as needed based on audit findings. The results of these audits will be shared wit the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	07/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

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

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F0756 SS = D	Continued from page 8 milligrams (MG) tablet- give 50MG by mouth once daily for HTN. Start date-2/26/26 Lisinopril 40MG table- give 1 tablet daily for HTN- start date 2/26/26 Amlodipine Besylate 10MG tablet- Give 1 tablet by mouth every night at bedtime for HTN- start date-2/25/26 R13's monthly pharmacy recommendation dated 3/13/26, indicated the pharmacist had requested hold parameters for the above medication orders. The document also shows the provider responded and ordered parameters for "HOLD if systolic blood pressure (SBP) is 100 or less." The order was signed and reviewed by two different nurses on 3/19/26 and 3/20/26. However, R13's medical record had no evidence the parameters were ever added to the orders. On 6/17/26 at 4:27p.m., the regional nurse consultant (RNC) accessed the facility's electronic charting system and confirmed the parameters of "HOLD for SBP less than 100" were never added to any of the 3 orders as directed by the physician. The RNC confirmed that even though the pharmacy recommendation was signed off it was never entered as ordered. On 6/18/26 at 09:10 a.m. pharmacist (PHRM) confirmed the parameters were never entered as ordered. PHRM stated their expectation was the facility addressed and completed the pharmacy recommendations and order changes within 30 to 60 days. The PHRM stated the importance of keeping the orders up to date because it could have had a negative effect on the residents. On 6/18/26 at 9:43 a.m. director of nursing (DON) stated the pharmacy emailed the monthly recommendations to the DON and they passed it on to the nurse managers for each wing. Nurse managers were responsible for following up on the recommendations. DON confirmed the parameter orders for R13 were never entered. Their expectation was it would have been completed as ordered. The DON stated the importance of having blood pressure parameter on blood pressure medications as ordered to prevent the residents blood pressure from dropping too low. The Consultant Pharmacist Reports Policy last revised January 2026 indicated the pharmacy recommendations are acted upon and documented	F0756		07/28/2026

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F0756 SS = D	Continued from page 9 by the facility staff and/or prescriber. The DON or designated licensed nurse address and document recommendations that do not require physician intervention, e.g., monitor blood pressure.	F0756		07/28/2026
F0847 SS = D	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident	F0847	F847 – Entering into Binding Arbitration Agreements The facility reviewed with R43 the binding arbitration agreement in a manner he could understand. Resident expressed understanding of the binding arbitration agreement. Facility completed an audit of residents and/or responsible parties who had signed the arbitration agreement prior to 5/1/2026. The identified residents were explained the binding arbitration agreement in a clearly communicated manner for them and/or their responsible party to understand. Residents and/or responsible parties were able to express understanding of the binding arbitration agreement by signature of the binding arbitration agreement. The facilities binding arbitration agreement was reviewed and remains current. Admissions Coordinator and Social Services were educated on the binding arbitration agreement specifically to ensure it is clearly communicated in a form and manner resident and/or responsible party understood prior to signing. The facility will audit 3 new admissions per week to ensure they understood the binding arbitration agreement prior to signing for 4 weeks, then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Administrator and/or Designee will be responsible party.	07/28/2026

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F0847 SS = D	Continued from page 10 or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure binding arbitration agreements were clearly communicated in a form and manner residents understood prior to signing for 1 of 3 residents (R43) reviewed for binding arbitration. This had the potential to affect residents who signed binding arbitration prior to 5/1/26. Findings include: R43's admission Minimum Data Set (MDS) indicated admission on 7/30/25, intact cognition with diagnoses of non-Alzheimer's dementia, and moderate vision impairment (limited vision: not able to see newspaper headlines but can identify objects), and R43 always needed to have someone help with reading written materials. Exhibit H- Binding Arbitration Agreement undated, included signature of R43. During interview on 6/17/26 at 11:23 a.m. R43 stated he would have not signed a binding arbitration agreement. R43 stated legal issues at the time of his admission would have kept him from signing an arbitration agreement. He would never agree to a mediator. He was not able to "read or write" and would therefore require assistance. During interview on 6/17/26 at 3:19 p.m. social services (SS)-A stated he completed binding arbitration with R43. He explained binding arbitration as a legal form allowing residents to speed up the process when bringing the facility to court. "I [SS-A] would not have stated they were giving up any rights." SS-A stated he had limited training on binding arbitration. He was responsible for all binding arbitration agreements until 5/1/26, when it was transferred to the admission coordinator. During interview on 6/17/26 at 3:29 pm. admission coordinator (AC) stated she had recently been hired and presented binding arbitration upon admission. She stated if a resident did not understand, she would stop and discuss binding arbitration with family. On 6/18/26 at 10:00 a.m. Administrator stated all binding arbitration agreements were grandfathered in. A facility document titled "Explanation of Arbitration Agreement Language to Family and Resident/Patient" indicated arbitration does not occur in a court. however, the document lacked indication the agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a	F0847		07/28/2026

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F0847 SS = D	Continued from page 11 language the resident and his or her representative understands. Further, it lacked resident/representative acknowledgement that he or she understands the agreement.	F0847		07/28/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F0883	F883 – Influenza and Pneumococcal Immunizations R11 and R76 were offered the pneumococcal vaccination series based on CDC recommendation and will be administered based on resident and/or responsible party decision. Facility completed an audit of all current residents vaccination status of pneumococcal and will offer and administer vaccination based on resident and/or responsible party decision. The facilities Pneumococcal policy was reviewed and remains current. Licensed Nurse staff were educated to ensure pneumococcal vaccinations were appropriately offered and administered based on vaccination consent form. The facility will audit 3 new admissions per week to ensure pneumococcal vaccinations were offered and administered based on vaccination consent form for 4 weeks, then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	07/28/2026

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F0883 SS = D	Continued from page 12 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents (R11, R76) were offered, educated and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC), who were reviewed for immunizations. Findings include: A CDC Adult Immunization Schedule by age topic, dated 08/07/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 50 years old had not received the complete series of pneumococcal vaccination (i.e., PPSV23, PCV20 and PCV13) or their history is unknown, then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20), 1 dose of PCV-15, or PCV-21. R11’s quarterly Minimum Data Set (MDS) dated 5/29/26, indicated R11 was admitted on 11/26/25, 87 years old, severely cognitively impaired, and had the following diagnoses: hypertension (HTN) (high blood pressure), renal insufficiency, diabetes (DM), non-Alzheimer’s dementia, depression, malnutrition, and psychotic disorder other than schizophrenia. R11’ s undated client information vaccination record indicated R11 was due for their next pneumonia vaccination.	F0883		07/28/2026

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F0883 SS = D	Continued from page 13 R11's immunization informed consent form signed 12/3/25, indicated R11 had given consent to receive the PCV20 vaccination. R11's medical record lacked any evidence the PCV20 was ever provided. R76's quarterly MDS dated 4/14/26, indicated R76 was admitted on 4/19/2024, 78 years old, cognitively intact, and had the following diagnoses: HTN, neurogenic bladder (bladder unable to empty on its own), DM, paraplegia (inability to move one's limbs), seizure disorder, depression, malnutrition, and bipolar disorder. R76's undated client information vaccination record indicated R76 was due for their next pneumonia vaccination. R76's medical record lacked any evidence the PCV20 was ever provided. R76's immunization informed consent form signed 9/23/25, indicated R76 had not been offered the PCV20 vaccination. On 6/16/26 at 3:35 p.m. regional Nurse consultant (RNC) stated she was responsible for infection prevention while the current infection preventionist was on vacation. She confirmed neither R11 or R76 were offered the PCV20, and it had been missed. RNC stated their expectation was for the vaccinations to have been offered and provided upon admission. Furthermore, RNC stated the importance of providing vaccinations according the to the CDC recommendations was to keep the residents healthy. The facility's Pneumococcal policy last revised 2/24, indicated prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident will be offered the vaccine, when indicated, unless the resident had already been vaccinated or the vaccine is medical contraindicated.	F0883		07/28/2026

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E0039	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and	E0039	E39 – EP Testing Requirements Facility completed a tabletop exercise of elopement. All residents have the potential to be affected by the deficient practice. Administrator was educated to ensure development and maintaining an emergency preparedness plan training and testing program specific to full-scale community-based exercises, tabletop exercised and/or live emergency preparedness events. The facility will audit annually to ensure 2 of the following are completed as part of emergency preparedness training and testing program including full-scale community-based exercises, tabletop exercise and/or live emergency preparedness events. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audit. Regional Director of Operations and/or Designee will be responsible party.	07/28/2026

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E0039	Continued from page 15 emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual	E0039		07/28/2026

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E0039	Continued from page 16 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:	E0039		07/28/2026

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E0039	Continued from page 17 (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or	E0039		07/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

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

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E0039	Continued from page 18 prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]:	E0039		07/28/2026

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ST ANTHONY HEALTH & REHABILITATION	3700 FOSS ROAD NORTHEAST , ST ANTHONY, Minnesota, 55421

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E0039	Continued from page 19 (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or	E0039		07/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

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E0039	Continued from page 20 man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.	E0039		07/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

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E0039	Continued from page 21 *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and maintain an emergency preparedness plan (EPP) training and testing program which was based on the emergency plan, risk assessment, policies and procedures. This had the potential to affect all 92 residents residing at the facility. Findings include: Review of the facility's EP program revealed the facility had conducted a full-scall community-based exercise on 9/16/25, however lacked any evidence of the required second exercise ever being conducted. On 6/18/26 at 12:33 p.m., the administrator confirmed they did not complete the required second exercise. The facility EPP policy was requested and none was provided.	E0039		07/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Health & Rehabilitation	**3700 FOSS ROAD NORTHEAST , ST ANTHONY, Minnesota, 55421**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/16/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Anthony Heath & Rehabilitation was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		07/02/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. Anthony Health and Rehabilitation is a 2-story building without a basement that was built in 1967 and was determined to be of Type II(111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility shares a common wall with an assisted living facility that has a 2-hour fire rating. The facility has a capacity of 110 beds and had a census of 92 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		07/02/2026
K0311 SS = F Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101	K0311	K311 – Vertical Openings – Enclosure The missing ceiling tiles in the linen closet near room 200 were installed.	07/28/2026

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K0311 SS = F Bldg. 01	Continued from page 2 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 06/16/2026, at 12:03 PM, by observations and staff interview revealed that several ceiling tiles were missing from the linen closet near room 200. This condition would delay the activation of the fire alarm and sprinkler system in the event of an emergency. An interview with the Campus Director, Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery	K0311	Continued from page 2 All residents had the potential to be affected by the deficient practice. Other linen closet and storage rooms were inspected to ensure ceiling tiles were not missing. Maintenance staff were educated to ensure there are no missing ceiling tiles throughout the facility. The facility will audit 3 linen closets and/or storage rooms weekly to ensure appropriate ceiling tiles are installed for 4 weeks, then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Maintenance Director and/or Designee will be responsible party.	07/28/2026
K0920 SS = F Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K0920	K920 – Electrical Equipment – Power Cords and Extens The refrigerator, microwave and toaster in the MDS office were appropriately removed and/or appropriately plugged into the appropriate electrical receptacles. An audit of all offices within the facility were reviewed to ensure no inappropriate utilization of power cords. Leadership staff educated on appropriate utilization of power cords within their offices. The facility will audit 3 offices per week to ensure appropriate utilization of power cords for 4 weeks,	07/28/2026

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K0920 SS = F Bldg. 01	Continued from page 3 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 06/16/2026 at 12:10 PM, it was revealed by observation that a refrigerator was plugged into a power strip in the Nurse Managers office. The Maintenance Director removed this deficient practice at the time of discovery. 2. On 06/16/2026 at 12:19 PM, it was revealed by observation that a refrigerator, microwave and toaster were plugged into a power strip in the MDS office. 3. On 06/16/2026 at 12:23 PM, it was revealed by observation that a microwave was plugged into a power strip in the Life Enrichment office. The Maintenance Director removed this deficient practice at the time of discovery. 4. On 06/16/2026 at 12:53 PM, it was revealed by observation that a microwave was plugged into a power strip in the Life Enrichment office. The Maintenance Director removed this deficient practice at the time of discovery These deficient findings were confirmed by the Campus Director, Regional Maintenance Director and the Maintenance Director at the time of discovery.	K0920	Continued from page 3 then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Maintenance Director and/or Designee will be responsible party.	07/28/2026

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K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.1, 8.4.3.5, and 8.3.3.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K0321	K321 – Hazardous Areas – Enclosure Soiled Utility Room door near room 241 and in Memory Care appropriately latches. Self-closing device installed on Soiled Utility Room on 1st floor to ensure appropriate closure. An audit of all soiled utility room doors was completed to ensure appropriate closure. Maintenance staff were educated to ensure appropriate closure of doors. The facility will audit 3 soiled utility doors per week to ensure appropriate closure for 4 weeks, then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Maintenance Director and/or Designee will be responsible party.	07/28/2026

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K0321 SS = E Bldg. 01	Continued from page 5 1. On 06/16/2026 at 12:15 PM, it was revealed by observation that the door to Soiled Utility Room near room 241 did not latch when closed. 2. On 06/16/2026 at 12:52 PM, it was revealed by observation that the door to Soiled Utility Room in memory care did not latch when closed. 3. On 06/16/2026 at 12:44 PM, it was revealed by observation that the door to Soiled Utility Room on the first floor was not equipped with a self-closing device, resulting in it not closing automatically. An interview with the Campus Director, Regional Maintenance Director and the Maintenance Director verified these deficient findings at the time of discovery.	K0321		07/28/2026
K0211 SS = D Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/16/2026 at 1:00 PM, it was revealed by observation that multiple serving carts were in the corridor between the facility and the assisted living facility restricting the clear width to 45". An interview with the Campus Director, Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery.	K0211	K211 – Means of Egress – General Carts and items in the corridor between the facility and the assisted living were moved to one side to ensure a clear width of 45”. Staff education initiated to ensure carts and/or items are on 1 side of the corridor. The facility will audit the corridor between the facility and the assisted living 3 times per week to ensure appropriate clearance for 4 weeks, then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Maintenance Director and/or Designee will be responsible party.	07/28/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Health & Rehabilitation	**3700 FOSS ROAD NORTHEAST , ST ANTHONY, Minnesota, 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
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have a isolated impact on the residents within the facility. Findings include: 1. On 06/16/2026 at 11:41 AM, it was revealed by observation that there were wires resting on the sprinkler pipe above the ceiling on the second floor near room 203. 2. On 06/16/2026 at 11:45 AM, it was revealed by observation that there were wires resting on the sprinkler pipe above the ceiling on the second floor near room 214. 3. On 06/16/2026 at 11:50 AM, it was revealed by observation that there were wires resting on the sprinkler pipe above the ceiling on the second floor near room 2229.	K0353	K353 – Sprinkler System The wires resting on the sprinkler pipe above the ceiling on 2nd floor near room 203 were removed. The wires resting on the sprinkler pipe above the ceiling on the 2nd floor near room 214 were removed. The wires resting on the sprinkler pipe above the ceiling on the 2nd floor near room 229 were removed. An audit of above ceiling wires was completed to ensure no wires were on the sprinkler pipes. The facility will audit 3 areas weekly in the ceiling to ensure no wires are on the sprinkler pipes for 4 weeks, then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Maintenance Director and/or Designee will be responsible party.	07/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

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K0353 SS = D Bldg. 01	Continued from page 7 An interview with the Campus Director, Regional Maintenance Director and the Maintenance Director verified these deficient findings at the time of discovery.	K0353		07/28/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on	K0363	K363 – Corridor – Doors The door leading from the kitchen to the assisted living corridor has been measured by a contractor for a replacement door and being ordered. The replacement door will have all appropriate latching hardware. The facility will audit the door monthly once installed to ensure appropriate latching for 4 months then as needed based on audit findings. The results of these audits will be shared with the facilities QAPI committee for input on the need to increase, decrease, or discontinue the audits. Maintenance Director and/or Designee will be responsible party.	07/28/2026

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K0363 SS = D Bldg. 01	Continued from page 8 the residents within the facility. Findings include: On 06/16/2026 at 1:00 PM, it was revealed by observation that the door leading from the kitchen to a corridor leading to the assisted living facility is missing latching hardware and the door is being latched by a slide bolt latch attached to the top of the door. An interview with the Campus Director, Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery.	K0363		07/28/2026