



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 25, 2026

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

RE: CCN: 245063

Cycle Start Date: August 13, 2026

Dear Administrator:

On August 13, 2026, a 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 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:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 November 13, 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 February 13, 2027 (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,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us



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August 25, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 284EF6-H1

Dear Administrator:

The above facility survey was completed on August 13, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of

compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2026	
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE , SAINT PAUL, Minnesota, 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
E0000	Initial Comments On 8/10/26 to 8/13/26, 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			09/04/2026
F0000	INITIAL COMMENTS On 8/10/26 to 8/13/26, a standard recertification and licensure survey S5063039 was conducted at your facility. In addition, multiple complaint investigations were also completed. Your facility was not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued: H50633621C iQies 232944858 H50633620C iQies 235955852 H50633619C iQies 247464490 H50633618C iQies 257573250 H50633618C iQies 257868783 H50633617C iQies 261389089 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			F0000			

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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F0000	Continued from page 1 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 that substantial compliance with the regulations has been attained.			F0000			09/04/2026
F0949 SS = E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 8 staff nursing assistant (NA)-M had completed the required Alzheimer's and dementia care training program. This had the potential to affect all residents in the facility who had an Alzheimer's or dementia diagnosis. Findings include: On 8/13/26 at 8:48 a.m., a request was made to the administrator and the director of nursing (DON) for Alzheimer's and/or dementia care training for eight employees. During an interview on 8/13/26 at 12:05 p.m., the administrator stated they were unable to find Alzheimer's or dementia care training for NA-M who had a start date of 9/9/25. It is the expectation all staff were to receive Alzheimer's and/or dementia care training before working with residents and should also have documentation of the training being completed. A policy related to Alzheimer's and dementia care training was requested, but none was received.			F0949	F949 Behavioral Health Training Immediate Corrective Action: NA-M completed Dementia Care Training with a follow-up quiz Identification of other residents/areas with the potential to be affected A full audit of all current staff personnel files was conducted to confirm completion of required Dementia Care Training and to identify any other staff with missing or undocumented training. Any additional staff found without completed dementia training completed dementia training with a follow-up quiz. Systemic Measures/Prevention of Recurrence: The facility developed and finalized a written Alzheimer's and Dementia Care Training policy specifying that all staff must complete this training prior to independent resident contact and annually there after Human Resources created a tracking tool to ensure Alzheimer's and Dementia Care training completion Monitoring/Quality Assurance to Sustain Compliance Human Resources Coordinator will audit new hire training completion weekly for the first 90 days after implementation and monthly thereafter. A monthly training compliance report will be		09/04/2026

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F0949 SS = E				F0949	Continued from page 2 reviewed by the Administrator to confirm 100% completion of required Alzheimer's/dementia training for staff. Results will be reported to the QAPI Committee monthly for three months to confirm sustained compliance. Responsible Party: HR Coordinator, which oversight by the Administrator Completion Date: 9/4/26		09/04/2026
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document			F0561	Resident #5 lights were replaced in accordance with her preferences. Educated staff on floor to use tels or the grievance process when a resident has repairs issues with things in rooms. The facility has determined that all residents haver potential to be affected. Assistant Administrator has done house wide interviews to see if any residents have any concerns with resident rights. 9/1/26 and 9/2/26 All staff were educated on how to bring resident concerns by filling out a tels in PCC or filling out a grievance form to ensure timely response to concerns. Administrator or Designee will do a weekly rounding interview audit for a month and then monthly for 3 months. QA results with be brought to monthly QAPI until compliance is maintained. 9/4/26		09/04/2026

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F0561 SS = D	Continued from page 3 review, the facility failed to honor a request for different room lighting for 1 of 1 resident (R5), reviewed for self-determination. Findings include: R5's quarterly Minimum Data Set (MDS) dated 6/8/26, indicated a diagnosis of moderate unspecified dementia. Behaviors related to disorganized thinking, altered level of consciousness, or difficulty focusing attention were not present. R5's care plan dated 6/23/26 included a primary diagnosis of Sjogren syndrome (an autoimmune disorder where the immune system attacks the body's moisture producing glands) with keratoconjunctivitis (inflammation of the cornea), which can cause pain, impaired eyesight, and light sensitivity. During observation and interview on 8/11/26 at 12:49 p.m., R5 was noted to be cognitively alert and able to answer questions appropriately. R5 stated she "really hated" the lights in her room. She described the lighting as too white, bright, and harsh. The two lights which bothered her the most were the circular overhead light located between the two resident spaces in the room and the rectangular wall light above her bed. Nursing assistant (NA)-A was in the room during the interview. R5 mentioned the bright lights to NA-A and he responded by shutting the lights off. The resident stated, "That is what they always do whenever I complain about the lights. They just shut them off". The resident stated she would prefer different bulbs, with a softer, more yellow light. During an interview on 8/12/26 at 8:49 a.m., registered nurse (RN)-B stated if a resident complained about the lighting in their room, she would complete a work order form and forward it to maintenance. She said R5 had occasionally complained the light in her room was too bright and RN-B said she usually responded by turning off the lights. She had not completed a work order for R5. RN-B mentioned she once had a request from another resident to remove the light bulb completely from a fixture in the room but was told by maintenance that they could not do that. During an interview on 8/12/26 at 9:04 a.m., the Director of Maintenance (DOM) stated the normal process for replacing lighting in a resident room was for nursing staff to send him a maintenance request. He said he had not received any requests recently for different lighting or light bulbs in any of the rooms, but he could change out the bulbs if lights			F0561			09/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2026	
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F0561 SS = D	Continued from page 4 were too bright. The DOM stated he had a variety of bulbs available, including a good stock of the older halogen and incandescent light bulbs. During an interview on 8/12/26 at 1:59 p.m., RN-A stated if a resident mentioned the lights were too bright in their room, staff were expected to offer to turn them off. If a resident expressed concerns regarding the type of light in their room, RN-A stated staff were expected to submit a work order request to maintenance. She was not aware of R5's request and had not submitted a work order. During an interview on 8/13/26 at 11:23 a.m., the Director of Nursing (DON) stated nursing staff were expected to contact maintenance if a resident complained about the lighting or requested a different type of lighting in their room. A policy regarding resident choices was requested but not received.			F0561			09/04/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical			F0605	The Medication regimen for R12 was reviewed by Hospice. The Antipsychotic medication prescribed PRN was discontinued on 8/19/26 The facility determined that all residents have the potential to be affected. A review of all PRN medication orders and indications for use was completed on 8/26/26. All Licensed Nursing staff were In serviced regarding the policy "The Use of Psychotropic Medication" 9/1/26 and 9/2/26. On 9/2/26 Zoom meeting was help with all MD. NP and Medical director to go over regulation and policy. DON or Designee will complete random weekly audits for 4 weeks, then monthly for 3 months till resolved. Audits records will be reviewed by QAPI team Monthly until compliance has been achieved. Corrective Action complete on 9/4/26		09/04/2026

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F0605 SS = D	Continued from page 5 symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless			F0605			09/04/2026

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F0605 SS = D	Continued from page 6 the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a PRN (as-needed) antipsychotic medication was limited to 14 days and that the continued use of the PRN antipsychotic medication was evaluated by the attending physician or prescribing practitioner for 1 of 1 residents (R12) reviewed for unnecessary medications. Findings include: R12's admission Minimum Data Set (MDS) dated 7/8/26, identified R12 had a severe cognitive impairment and diagnoses that included Alzheimer's disease and dementia. R12 received hospice services and used antipsychotic, antianxiety and opioid medications. R12's care plan revised 7/16/26, The resident has a behavioral problem of refusing cares and wandering related to Alzheimer's disease, peripheral vascular			F0605			09/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2026	
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE , SAINT PAUL, Minnesota, 55108			
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F0605 SS = D	Continued from page 7 disease and dementia with agitation. Staff were directed to: • Administer medications as ordered. Monitor/document for side effects. • Explain all cares to the resident before starting and allow time to adjust to changes. • Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. R12's Order Summary Report dated 8/11/26, identified the following orders: 7/4/26 - 7/8/26 haloperidol 2 milligram (mg)/milliliter (ml) solution Give 0.5 ml by mouth every 4 hours as needed (PRN) for agitation and delirium. 7/8/26 - 7/10/26 haloperidol 2mg/ml solution Give 0.5 ml by mouth every 4 hours as needed for agitation and delirium for 10 Days. 7/10/26 – open ended haloperidol 2mg/ml solution Give 0.5 ml by mouth every 4 hours as needed for agitation and delirium. The 7/10/26 order was written as open-ended, rather than being limited to 14 days as required for a PRN antipsychotic medication. R12's Electronic Medication Administration Record (EMAR) dated 7/2026, identified R12 received a PRN dose of haloperidol 6 times. R12's EMAR dated 8/11/26, identified R12 had received a PRN dose of haloperidol 1 time. R12's physician progress note dated 7/7/26, indicated R12 had Alzheimer's disease with late onset: advanced dementia with behavioral disturbance. R12 exhibited advanced cognitive impairment and was disoriented, unable to make needs known. R12 had a history of agitation, nonsensical speech and required assistance with all activities of daily living (ADLs). R12 had no reported hallucinations and had intermittent agitation. Continue haloperidol 1 mg every 4 hours PRN agitation. Maintain structured environment and safety precautions. R12's physician progress note dated 7/28/26 identified R12 had advanced dementia and was unable to reliably communicate needs. R12 had a			F0605			09/04/2026

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F0605 SS = D	Continued from page 8 history of agitation which was currently controlled, no reported hallucinations, and required full assistance with ADLs. The physician directed continuation of haloperidol 1 mg (0.5 mL) every 4 hours PRN for agitation and continued non-pharmacological behavioral interventions. However, the note did not identify an evaluation addressing the appropriateness and continued need for the PRN antipsychotic medication or provide an adequate rationale for renewal of the PRN order. R12’s nursing progress note dated 7/10/26 at 6:20 a.m., identified a monthly regimen review (MRR) - see report for recommendation. R12’s MRR dated 7/10/26 was requested but not received. R12’s nursing progress note dated 7/19/26 at 2:07 p.m., identified R12 was an 84 years old male and was alert and oriented with confusion. R12 needed two assist for transferring and ADLs. R12 became restless that morning, and PRN haloperidol 0.5 ml was administered at 9:17 a.m. and was effective. However, the note failed to identify what non-pharmacological interventions were attempted prior to administration of haloperidol. During an interview on 8/12/26 at 1:58 p.m., licensed practical nurse (LPN)-C stated R12 did have a “lot” of agitation when he was first admitted to the facility R12 would stand up, try to walk and fall. “It was really bad there for a while”. R12 had settled down and became “used” to living at the facility. Staff sat with R12, tried to calm him down and then if nothing worked, R12 had a PRN medication as well. During an interview on 8/13/26 at 9:01 a.m., the director of nursing (DON) stated R12 should have had a 14-day face-to-face evaluation to ensure the ongoing need for PRN antipsychotropic medication to prevent unnecessary medications or unnecessary sedation. During a telephone interview on 8/13/26 at 8:01 a.m., the pharmacist stated she had reviewed R12’s medications on 7/10/26 and again on 8/12/26. On 7/10/26, the pharmacist stated she informed the facility R12’s haloperidol did not have an appropriate rationale for use and that PRN antipsychotropic medications required a face-to-face medical provider evaluation every 14 days to ensure the PRN order needed to be continued. On 8/12/26, R12’s haloperidol order was discontinued, and the pharmacist had no further recommendations. The			F0605			09/04/2026

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F0605 SS = D	Continued from page 9 pharmacist stated agitation and delusions were an inappropriate indication for use and PRN medications needed to be evaluated every 14 days to prevent misuse such as staff convenience. The facility policy Use of Psychotropic Medication undated, identified psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted: PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.			F0605			09/04/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate.			F0628	F628 Discharge Process Immediate Corrective Action: R79 was discharged prior to the survey. Identification of Other Residents/Areas with the Potential to be Affected: A look-back audit of hospital transfers over the prior 30 days was conducted to identify any other residents for whom written transfer and notices were not sent or provided to the resident or representative and this was corrected by sending a transfer and discharge notice. Systemic Measures/Prevention of Recurrence: The facility's Transfer and Discharge policy ad Bed Hold Notice policy were reviewed and clarified to require that a written transfer notice and written		09/04/2026

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F0628 SS = D	Continued from page 10 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or			F0628	Continued from page 10 bed-hold notice accompany or be issued concurrently with, every hospital transfer. Licensed nursing staff were re-educated on the requirement to complete and send both a written transfer and discharge notice and written bed-hold notice for every resident hospitalization or discharge (if applicable) and the importance of ensuring the bed-hold is signed even if they received a verbal. Every discharge/transfer will be audited within 24-72 hours to ensure completion of bed-hold and transfer and discharge notice. Audit results will be brought to QAPI for review. 4. Person Responsible: Administrator/Designee 5. Completion: 9/4/26		09/04/2026

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F0628 SS = D	Continued from page 11 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.			F0628			09/04/2026

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F0628 SS = D	Continued from page 12 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.			F0628			09/04/2026

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F0628 SS = D	Continued from page 13 (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure written transfer notices were provided as soon as practicable for 1 of 1 resident (R79) reviewed for hospitalization. Findings include:R79's comprehensive Minimum Data Set (MDS) dated 2/19/26, indicated R79 had severe cognitive impairment. R79's progress note dated 2/7/26 at 12:12 a.m., indicated R79 slept most of the time, had a decreased level of consciousness, and was nonverbal. R79's daughter was designated as her legal representative. R79's progress noted dated 7/4/26 at 11:28 p.m., indicated R79 was transferred to the emergency department by ambulance for labored respirations and a change in level of consciousness. The note indicated verbal consent was obtained via phone from R79's daughter for a bed hold. A review of R79's medical record lacked evidence that written transfer and bed-hold notices were sent with R79 to the hospital and/or provided to the resident representative. During an interview on 8/12/26 at 8:06 a.m., licensed practical nurse (LPN)-A stated she sent documents such as a medication list, the most recent vital signs, and Physician's Orders for Life-Saving Treatment (POLST) with any resident who transferred to the hospital. LPN-A stated she was not familiar with a written transfer notice. She said standard practice was to contact family to see if they wanted to place a bed hold. If they did, she filled out a paper bed-hold form. This form was kept at the facility and was not sent with the patient or given to the resident representative. During an interview on 8/12/26 at 9:06 a.m., LPN-B stated the paperwork sent with residents transferring to the hospital included the resident's face sheet, diagnoses, POLST, medications, immunizations, and most recent progress note. Bed holds were documented on a paper form which was then			F0628			09/04/2026

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F0628 SS = D	Continued from page 14 scanned to the resident's medical record. LPN-B stated she completed a progress note when a resident transferred to the hospital which typically said, "911 called. Paperwork sent. Bed hold placed". She stated written transfer notices or bed-hold forms were not sent with the resident or provided to the resident's representative. She said a copy of the bed-hold notice was faxed to the ombudsman and the Minnesota Department of Human Services (DHS) by the medical records department. During a subsequent interview on 8/12/26 at 10:15 a.m., LPN-A confirmed she was unable to find either a written transfer notice or a written bed hold notice associated with R79's transfer to the hospital on 7/4/26 in R79's medical record. During an interview on 8/13/26 at 1:47 p.m., the Director of Nursing (DON) stated when a patient transferred to the hospital, the resident or family was asked whether they would like to hold the bed. Nursing staff filled out a paper bed-hold form and then gave this to medical records to be scanned into the resident's chart. The DON stated she did not know if a written transfer notice and/or a written bed hold notice was required to be sent with the resident or provided to the resident's representative. An undated policy titled Transfer and Discharge (including AMA) provided by the facility on 8/13/26, indicated that in the event of a transfer or discharge, the facility's transfer/discharge notice will be provided to the resident and/or the resident representative in a language and manner in which they can understand. The notice was to include the details of the transfer and information on how to appeal the transfer. The Transfer and Discharge policy also specified the information that was to be given to the receiving provider in the event of a transfer. An undated policy titled Bed Hold Notice provided by the facility on 8/13/26, indicated that in the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The written bed-hold notice was to specify the duration of the State bed-hold policy, the reserve bed payment policy, the facility policies regarding bed-hold periods, and the conditions upon which the resident would return to the facility.			F0628			09/04/2026

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F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 1 residents (R77) reviewed for MDS accuracy. Findings include: R77's quarterly Minimum Data Set (MDS) dated 6/23/26, identified R77 had a severe cognitive impairment and diagnoses that included Type I Diabetes and Alzheimer's disease. The MDS also identified R77 had 2 deep tissue injuries (DTI) and			F0641	Resident #77 was re-assessed on 8/24/26 to show that No pressure ulcer was noted in reference period, MDS was modified with correct information. An Audit on everyone with wounds who has had an MDS in the last 30 days was audited and corrected if needed. The facility determined that all residents with wounds have the potential the be affected. An in-service was conducted by Regional Clinical Nurse, with MDS Coordinator addressing the importance of identifying the documentation of wound care and staging and the look back period for coding on MDS and reviewed the RAI Manual Section M - M0100-M0300G. The DON or Designee will conduct weekly audits on 5 MDS a week receiving wound care for weeks and monthly for 3 months till resolved. The resident and their medical records will be assessed to ensure that the correct documentation on MDS for wound care matches what's in medical record. POC will be brought to QAPI monthly until compliance has been met 9/4/26		09/04/2026

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F0641 SS = D	Continued from page 16 used a pressure reducing device for her bed and chair. However, R77's electronic medical record (EMR) identified R77's DTI were healed 6/9/26. R77'S Weekly Wound Documentation dated 6/9/26, identified R77's DTI on each heel had healed. R77's physician order dated 6/9/26 to 7/7/26, identified Wound Care - Left Heel Unstageable DTI Using Clean / Aseptic Technique 1. Apply Skin Prep to area and let dry daily and as needed. During an interview on 8/12/26 at 2:02 p.m., registered nurse (RN)-E stated R77 did have a deep tissue area to each of her heels, but the areas had healed and R77's weekly wound notes reflected that. During an interview on 8/12/26 at 2:07 p.m., RN-G stated she was responsible for completing R77's MDS. RN-F reviewed all assessments and R77's medical record to gather the required information. RN-F stated she was unsure why she had entered R77 had two DTI. RN-F stated she would do further review, but to find out if it was entered in error. RN-F stated MDS accuracy was very important because it affected billing and proper resident care because it determined what would be care planned for R77. At 2:45 p.m., RN-F stated she had entered two DTI for R77 because R77 had been receiving wound care until 7/7/26. At 2:57 p.m., RN-E stated R77's wounds were healed on 6/9/26 and the following wound care until 7/7/26 was a preventative measure. RN-F stated the DTI should not have been identified on R77's MDS and the DTI was entered in error. During an interview on 8/13/26 at 9:12 a.m., the director of nursing (DON) stated MDS accuracy affected "everything": level of care, the resident care plan, "just everything" and should reflect the resident's current needs. A MDS accuracy facility policy was requested but not received.			F0641			09/04/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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;			F0677	Nail cares were completed on resident #5 and #58. DON and Nurse Management Team did an audit to make a list of residents requiring specialized nail care due to high risk of conditions and made referral to podiatrist. A shaving audit was performed. Facility has determined all residents have the		09/04/2026

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F0677 SS = D	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care, shaving) was provided for 2 of 2 residents (R58, R5) reviewed for activities of daily living (ADLs) and were dependent on staff for their care. Findings include: R58 R58's quarterly Minimum Data Set (MDS) dated 6/18/26, indicated R58 was cognitively impaired, had no behaviors, did not refuse personal cares, needed maximal assistance with personal hygiene, and was dependent on toileting hygiene and bathing. R58's Clinical Diagnosis report dated 8/12/26, indicated diagnoses of unspecified dementia with mood disturbance, macular degeneration, major depressive disorder, hypertension, and vascular dementia. R58's Activities of Daily Living (ADLs) Care Plan dated 8/12/26, indicated R58 had a self-care deficit related to moderate cognitive impairment and diagnosis of dementia. R58's care plan indicated she was dependent on staff with bathing and personal hygiene. During observation on 8/10/26 at 12:32 p.m., R58 was awake in bed, but did not answer any questions. R58's nails were uneven in length and shape. The nails length ranged between 1 centimeter (cm) to 1.5 cm in length. During interview on 8/11/26 at 11:46 a.m., nursing assistant (NA)-C stated the NAs checked the residents' fingernails and toenails on shower days and cut them as needed. NA-C added the nurses cut the nails of residents with diabetes. During observation and interview on 8/12/26 at 8:21 a.m., R58 was in the dining room sitting up in her wheelchair. R58's clothes were clean, but her nails were still long, uneven and had black matter underneath. During interview on 8/12/26 at 8:36 a.m., licensed practical nurse (LPN)-B verified R58's fingernails were long, uneven, and had black matter underneath. LPN-B stated she would try to cut them, but most likely, R58 would refuse.			F0677	Continued from page 17 potential to be at risk. All staff in-service was held 9/1/26 and 9/2/26 on Nail cares and Resident shaving. ADL. policy was reviewed with all staff. A house wide audit was done to see what residents needed razors and POA were notified. On 8/31/29 Facility purchased eclectic razors that have interchangeable heads, so each resident can have their own. The DON or Designees will review residents with high-risk conditions and make appts as needed. Nurse Managers on each floor will monitor ADLs for all residents not able to perform on their own. DON or Designees will QA 5 residents weekly for 1 month and then monthly for 3 months till in compliance. Findings will be brought to QAPI monthly until in compliance. 9/4/26		09/04/2026

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F0677 SS = D	Continued from page 18 During interview on 8/13/26 at 9:51 a.m., director of nursing (DON) stated the residents' nails needed to be cut on their shower day. DON stated NAs were supposed to attempt cutting residents nails, and if they failed, NAs needed to report this failure to the nurses. The nurses also needed to reapproach to try and cut the residents' nails. DON stated the facility had ordered different nail care supplies and would try to file F58's fingernails. DON stated long nails get dirty and they were an infection control issue. Requested a facility's policy about Nail Care but none was provided. R5 R5's quarterly Minimum Data Set (MDS) dated 6/8/26, indicated a diagnosis of moderate unspecified dementia. Behaviors related to disorganized thinking, altered level of consciousness, or difficulty focusing attention were listed as not present. R5's MDS indicated she was dependent on staff for personal hygiene and toileting and required maximal assistance with showering/bathing. A review of R5's care plan dated 6/23/26, did not specify the need to assess and shave facial hair. During an interview on 8/10/26 at 3:27 p.m., R5 was noted to be cognitively alert and able to answer questions appropriately. She stated that the whiskers on her chin really bothered her and she wished she could do something about them. Light grey hairs approximately 1/4 inch in length were observed to extend across the bottom of R5's chin. R5 mentioned this facial hair on three different occasions throughout the interview, and she vigorously rubbed the whiskers back and forth with her hand several times. R5 stated she has mentioned the whiskers to staff "multiple times" but had never received any response or any offers to shave them. During observation on 8/11/26 at 12:47 p.m., facial whiskers were still visible on R5's chin. During an interview on 8/11/26 at 3:35 p.m., nursing assistant (NA)-A stated shaving depended on resident preferences. Most residents preferred to be shaved every day. Orders were not typically placed for shaving as it was considered a "thing we just do". NA-A said many residents had their own razors			F0677			09/04/2026

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F0677 SS = D	Continued from page 19 but otherwise, the facility provided them. He stated female residents were not typically asked about shaving facial hair. He said he only knew of one woman who shaved her facial hair regularly and she did this herself. NA-A said he had not received a request from R5 to shave her facial hair, and he has never offered to do it for her. During an interview on 8/11/26 at 3:48 p.m., NA-B stated that her residents varied in terms of shaving requests. She said that she shaved her residents every day unless they told her not to. NA-B stated if a female resident requested to be shaved, she would just do it. She has never asked a female resident if they wanted their facial hair to be shaved. During observation on 8/12/26 at 11:35 a.m., facial whiskers were still evident on R5's chin. During an interview on 8/12/26 at 1:55 p.m., registered nurse (RN)-A stated shaving was not typically included in the care plan. She said NAs were expected to shave or offer shaving to every resident each morning. Shaving was considered a standard of care, like brushing teeth, washing faces, applying deodorant, etc. NAs were also expected to offer shaving to female residents, especially if they noticed unexpected facial hair. During an interview on 8/13/26 at 11:20 a.m., the Director of Nursing (DON) stated daily shaving was a standard of care for both males and females. She stated that NAs were expected to offer this service to every resident and if a resident refused, the NA should inform the RN so the refusal could be documented in the chart and the care plan updated. A policy titled Activities of Daily Living (ADLs) dated 4/15/26, indicated care and services were provided by the facility for bathing, dressing, grooming, and oral care and that a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good grooming and personal hygiene. An undated policy titled Grooming a Resident's Facial Hair received on 8/13/26, specified that it was the practice of the facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice.			F0677			09/04/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care			F0684	On 8/26/25 Nursing staff reassessed resident # 12 for need of arm sleeve and Skin was intact, due to cognition level of leaving on his arm and chewing on it. Skin integrity care plan was reviewed and updated with changes.		09/04/2026

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F0684 SS = D	Continued from page 20 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, interview, and record review, the facility failed to ensure a sleeve protector was provided in accordance with the comprehensive care plan for 1 of 1 residents (R12) reviewed for pressure ulcers. Findings include: R12's admission Minimum Data Set (MDS) dated 7/8/26, identified R12 had a severe cognitive impairment and diagnoses that included Alzheimer's disease, dementia and peripheral vascular disease. R12 required partial/moderate assistance with upper body dressing and footwear. R12 was at risk for pressure ulcer/injury but had no pressure ulcers. R12's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 7/8/26, identified R12 was at risk for pressure ulcers and required a pressure relieving device for his bed and chair. R12's care plan revised 7/28/26, identified R12 had a skin tear/potential for skin tear of the left anterior shin and left posterior calf related to falling and hitting self on wheelchair. Staff were directed R12 needed protective sleeves to his left elbow at all times. During an observation on 8/10/26 at 11:50 a.m., R12 was seated in his tilt-in-space wheelchair in the dining room eating his meal. R12 was not wearing a protective sleeve to his left elbow. During an observation on 8/11/26 at 11:00 a.m., R12 was seated in his tilt-in-space wheelchair in the dining room. R12 was reclined back and was audibly snoring with his mouth hanging open. R12 was not wearing a protective sleeve to his left elbow. During an observation on 8/11/26 at 1:30 p.m., R12 was sitting in his tilt-in-space wheelchair at the table in the dining room. R12 was awake and tapping on the table to the beat of the music playing on the radio. R12 was not wearing a protective sleeve to his left elbow.			F0684	Continued from page 20 The facility determined all residents with the potential for skin breakdown are at risk An in-service was help 9/1/26 and 9/2/26 on skin integrity and interventions working and not and the importance of keeping care plan up to date and current. A care plan sweep was completed 8/25/26-8/28/26 on all care plans with skin risks DON or designee will conduct weekly audits of care plans for 1 month and monthly for 3 months. to ensure skin integrity care plans are current. IT will be brought to QAPI monthly until in compliance 9/4/26		09/04/2026

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F0684 SS = D	Continued from page 21 During an observation on 8/12/26 at 7:10 a.m., R12 was sitting in his tilt-in-space wheelchair in the dining room. R12 was not wearing a protective sleeve to his left elbow. During an observation on 8/13/26 at 8:37 a.m., R12 was seated in his tilt-in-space wheelchair in the dining room. R12 was not wearing a protective sleeve to his left elbow. During an interview on 8/13/26 at 8:42 a.m., nursing assistant (NA)-D stated she had been the nursing assistant assigned to R12 all week. NA-D did not put the protective sleeve on R12 because if she did R12 would take it off and chew on it. During an interview on 8/13/26 at 8:51 a.m., registered nurse (RN)-D stated he was unaware R12 was not wearing the protective sleeve but R12 should wear a protective sleeve if it was a care planned intervention for R12. During an interview on 8/13/26 at 8:57 a.m., the director of nursing (DON) stated R12's sleeve protector should be assessed and removed from his care plan if inappropriate. However, staff were expected to follow the resident care plan to ensure the resident received the care needed for the resident. The facility policy Pressure Injury Prevention Guidelines revised 6/1/26, identified Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. In the absence of prevention orders, the licensed nurse will utilize nursing judgment in accordance with pressure injury prevention guidelines to provide care and will notify physician to obtain orders. The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. Considerations for needed modifications include: Development of a new pressure injury. Lack of progression towards healing or changes in wound characteristics. Changes in the resident's goals and preferences,			F0684			09/04/2026

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F0684 SS = D	Continued from page 22 such as at end-of-life or in accordance with his/her rights.			F0684			09/04/2026
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide the ordered services for the behavioral health needs for 1 of 1 resident (R22) reviewed for mood and behavior. Findings Include: R22's quarterly Minimum Data Set (MDS) dated 7/13/26, indicated R22 was cognitively intact, and had no hallucinations or delusions. The MDS indicated R22 was depressed, had trouble falling asleep, had poor appetite, and had diagnoses of heart failure, Parkinson's disease, anxiety and depression disorder. R22's Medical orders dated 7/13/26, indicated an order for escitalopram oxalate 10 milligrams daily for depression. This order was dated 7/30/24. R22's care plan dated 7/13/26, indicated resident had potential for alteration in mood related to depression, and anxiety. The interventions directed staff to arrange for a psychology and follow-up consult as indicated. It also directed staff to discuss with the resident any concerns, fears, and issues regarding health, or other subjects routinely. Furthermore, the care plan indicated R22 needed time to talk and encouragement to express her feelings. R22's medical record indicated she had a care conference on 7/6/26. The Social Services note indicated R22 was cognitively intact, had mild signs and symptoms for depression, and had no			F0740	F740 Behavioral Health Services Immediate Corrective Action: The Social Services Director obtained the necessary consent and submitted the psychology referral for R22 R22 was seen by the psychologist on 8/26/26 R22's care plan and social services notes were updated to reflect the current psychology visitation status Identification of Other Residents/Areas with the Potential to be Affected: The Administrator conducted a full audit of all social services assessments to determine a list of residents with psych services. They were all audited to ensure each referral was actually submitted and that visits were occurring and corrective action was taken if warranted. Systemic Measures/Prevention of Recurrence: The Facility reviewed and updated their Psychiatric Services Referral Process procedure and re-educated social services and nursing on the updated process. A referral tracking/visits log was developed. The Administrator/Designee will monitor the log weekly to confirm all ordered referrals have been submitted and visits are occurring as scheduled. The Administrator/Designee will audit the social services assessments and progress notes weeklyx4, and monthly thereafter to ensure psych referrals are being added to the log. Results will be reported to the QAPI Committee		09/04/2026

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F0740 SS = D	Continued from page 23 behaviors. The note also indicated R22 saw psychology on a regular basis. R22’s electronic medical record (EMR) identified an order for psychology to evaluate and treat. The order was dated 4/13/26. The EMR lacked documentation of psychology visits in the last 12 months, which contradicts 7/6/26 social services documentation that R22 saw psychology on a regular basis. During observation and interview on 8/10/26 at 1:17 p.m., R22 stated she got sad very often, especially when her son visited her. R22 said, “I just start crying and I can’t stop crying. I am sad, am thinking about dying. I am old, I know I am going to die.” R22 said she would like to talk to somebody. She said she used to talk to somebody, and it helped her. R22 said she would like to talk to a counselor. During interview on 8/12/26 at 2:26 p.m., DON stated social services oversaw the processing of psychology orders. During interview on 8/13/26 at 8:56 a.m., the social services director (SSD) stated R22 used to receive psychology services but was discharged in December 2024. SSD stated she received R22’s order dated 4/13/26, but did not send the referral to psychology. During a follow-up interview on 8/13/26 at 9:40 a.m., SSD stated she needed to obtain a new consent and send the referral to psychology. SSD added, when she started in March, she had not received very much training, and she was unaware the facility had in-house visits from psychology. The SSD stated if she knew about this service, she would have made a list of all the residents who did or were supposed to see psychology to ensure this was occurring. During interview on 8/13/26 at 9:44 a.m., DON stated she expected the social workers would fax the referral orders to psychology as soon as possible and have residents seen as ordered. Requested the facility’s policy about referral to psychosocial services but none was received.			F0740	Continued from page 23 monthly for a minimum of three months to ensure sustained compliance. Completion Date: 9/4/26		09/04/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from			F0757	The Medication Regimen for R#9 was reviewed by MD. The Indication for the prescribed drug is Hypertension and is clearly documented and the risk and monitoring for High-risk meds have been added to MAR/TAR.		09/04/2026

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F0757 SS = D	Continued from page 24 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure adequate monitoring was in place for 1 of 1 resident (R9) on a high-risk medication (i.e., a diuretic), reviewed for unnecessary medications. Findings include:R9's quarterly Minimum Data Set (MDS) dated 5/12/26, included diagnoses of coronary artery disease with angina pectoris (chest pain), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). R9's diagnoses also included moderate cognitive deficit and unspecified dementia with impaired decision making and poor short-term memory. A review of R9's order set located in the facility's electronic medical record (EMR) dated 6/5/26, listed the following provider orders: 9/8/21: Knee high compression bandages placed in the morning and removed at bedtime 3/4/25: Orthostatic blood pressure assessment completed weekly 7/7/25: 2-gram sodium diet 8/7/25: 40 milligrams (mg) of furosemide (Lasix), a			F0757	Continued from page 24 The facility has determined that all residents that are prescribed high risk medications have the potential to be affected. A review of all medications orders and indication of use was completed 8/25/26-8/28/26. All licensed nursing staff will be In serviced on 9/1/26 and 9/2/26regarding policy for unnecessary drugs. A copy of the regulation regarding unnecessary medications and the facilities policy was reviewed with MD, NP and Medical Director via zoom on 9/2/26. The DON or designees will complete weekly audits for 1 month and monthly audits for 3 months until resolved. audits will be brought to QAPI monthly until compliance is acheived. 9/4/26		09/04/2026

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F0757 SS = D	Continued from page 25 diuretic, to be given to be given by mouth once per day 4/7/26: Shortness of breath to be assessed three times per day R9's medical record lacked evidence of orders for weights or edema monitoring. R9s care plan dated 7/12/26, indicated R9 was on diuretic therapy related to excess fluid. Interventions listed included: administer diuretic medications as ordered by physician, monitor for side effects and effectiveness every shift, and report pertinent labs results to the provider. R9's care plan also indicated staff were to monitor/document/report any changes in edema and weight. However, the record lacked evidence of specific parameters for provider notification of changes in edema and/or weight. A nutrition/dietary progress note dated 1/8/26 at 5:08 p.m., indicated R9's furosemide was increased on 8/27/25, and R9 had the potential for weight fluctuations related to edema and the diuretic. A review of R9's weight summary dated 8/12/26, indicated weights were done monthly with the following results: 6/6/26: 227 pounds 7/13/26: 235 pounds 8/6/26: 227 pounds R9's medical record lacked evidence of provider notification of the eight-pound weight fluctuations. During an interview on 8/13/26 at 1:15 p.m., registered nurse (RN)-C stated she monitored for edema, shortness of breath, blood pressure changes, and congestion in any resident taking a diuretic. She expected weights to be ordered and completed weekly. During an interview on 8/13/26 at 1:37 p.m., RN-D stated he cared for R9 frequently. He stated since R9 was on furosemide, he monitored for shortness of breath and swelling. If he noticed an increase in edema, he obtained a weight and notified the provider. RN-D stated R9 wore compression bandages on his legs for edema, and these were put on by nursing staff in the morning and removed at night. RN-D stated he believed R9 was on weekly weights. However, after reviewing R9's record, he stated R9 did not have an order for weekly weights,			F0757			09/04/2026

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F0757 SS = D	Continued from page 26 and he confirmed there were no orders for edema monitoring and no specific parameters for provider notification. During an interview on 8/13/26 at 1:52 p.m., Nurse Practitioner (NP)-A. stated since R9 was on furosemide, nursing staff should check for worsening edema "regularly". She was not sure if the facility had edema monitoring in place, but she expected staff to take weights at least weekly and update her with a weight gain of greater than five pounds in a week. During an interview on 8/13/26 at 2:23 PM, the Director of Nursing (DON) stated for residents on furosemide, nursing staff were expected to regularly monitor for edema and obtain weights weekly. The DON confirmed weights were being done monthly for R9 and that there were no orders in place for edema monitoring. The DON also confirmed there were no parameters listed for provider notification when changes in weight and/or edema were noted. The DON stated that two weeks ago, she changed weights from monthly to weekly for all residents based on their diagnoses and/or medications, including diuretics. She stated R9 "must have been missed". A review of the policy titled High Risk Medications dated 4/12/26, stated the resident's plan of care shall alert staff to monitor for adverse consequences of any high-risk medications and include interventions to minimize the risk of adverse consequences.			F0757			09/04/2026
F0880 SS = D	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,			F0880	CNA admitting to not following policy after being educated on EHBP was terminated on 8/12/26 for knowingly putting residents at risk. Immediate education was provided to all staff on floor in huddle. The facility has determined that all residents have the potential to be affected. All personnel were in-serviced on 9/1/26 and 9/2/26 for EHBP, PPE and Hand Hygiene. Each staff member did a playback demonstration of hand hygiene and proper donning and doffing of PPE. DON or Designee will complete random QA's on Hand Hygiene, PPE and EHBP protocols weekly for 1 month, monthly for 3 months until in compliance. QA will be brought to monthly QAPI meeting until		09/04/2026

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F0880 SS = D	Continued from page 27 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 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.			F0880	Continued from page 27 compliance has been met. 9/4/26		09/04/2026

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F0880 SS = D	Continued from page 28 §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, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 1 resident (R10) reviewed for catheter and 1 of 1 resident (R2) reviewed for pressure ulcers. Findings include: R10's quarterly Minimum Data Set (MDS) dated 5/13/26, identified R10 had a moderate cognitive impairment and diagnoses that included Type 2 Diabetes and obstructive reflux uropathy (a blockage that stops urine from flowing normally through the urinary tract). R10 required an indwelling catheter and was dependent on staff for assistance with toileting. R10's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 1/4/26, identified R10 had an indwelling catheter. Interventions included were to ensure tubing was not kinked, bag was covered, monitoring for urinary tract infection (UTI) symptoms, etc. The CAA directed to review R10's care plan. R10's care plan revised 6/14/26, identified R10 required Enhanced Barrier Precautions (EBP) due to have an indwelling catheter. Staff were directed: • Alcohol based hand rub in room • Educate resident/ family on EBP and answer any questions or concerns • EBP per CDC guidelines • EBP signs on doors • Garbage in room by exit for personal protective equipment (PPE) removal • Gown/gloves prior to high care contact (face mask plus goggles must be worn in activity at risk for high splash or spray) • Incorporate periodic monitoring and assessment of adherence to recommended infection prevention practices			F0880			09/04/2026

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F0880 SS = D	Continued from page 29 • Use PPE during high contact dressing, bathing/showing, transferring, hygiene, changing linen, changing briefs, toileting device care or wound care. During an observation on 8/11/26 at 3:26 p.m., there was an isolation door caddy with disposable gowns and gloves hanging on R10 with a sign that stated R10 required EBP. Registered nurse (RN)-D and nursing assistant (NA)-E assisted R10 to his room and encouraged R10 to lie down for a while. RN-D put on a disposable gown and gloves but NA-E did not. NA-E cleared R10’s personal items from the top of R10’s bed and then assisted R10 to stand up from his wheelchair. At 3:28 p.m., NA-E pulled R10's wheelchair away from R10 while R10 stood holding his front-wheeled walker. NA-E assisted R10 to turn and sit on his bed, then removed R10’s shoes. At 3:29 p.m., NA-E assisted R10 to stand again and pulled down R10’s pants. R10 sat down on the bed again so NA-E could remove his pants paying attention to wear his indwelling catheter bag was, NA-E stated R10 was ok’ed to stand up on his own as well before asking R10 to stand back up. NA-E removed R10’s soiled brief and cleaned feces from R10’s skin using a disposable wipe. At 3:34 p.m., NA-E removed her gloves, washed her hands in the bathroom sink and left the room. RN-D assisted R10 to lie down on his bed. During an interview on 8/12/26 at 2:22 p.m., NA-E stated 5 weeks ago there was a meeting and staff were told it was facility policy to wear a gown and gloves with any resident that had a catheter. NA-E again stated it was facility policy and wasn’t a “state reg”. NA-E then stated that she was going to be honest and staff didn’t wear the gown or gloves when they were busy. During an interview with RN-E and RN-G on 8/12/26 at 2:57 p.m., RN-E and RN-G stated staff were expected to follow EBP per CDC guidelines. During an interview on 8/13/26 at 9:07 a.m., the director of nursing (DON) stated EBP was an important intervention to stop the spread of infection for residents without indwelling catheters and staff			F0880			09/04/2026

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F0880 SS = D	Continued from page 30 were expected to follow EBP according to CDC guidelines. R2 R2's comprehensive Minimum Data Set (MDS) dated 7/13/26, indicated R2 was cognitively intact. Diagnoses included multiple sclerosis, obesity, diabetes mellitus, and a right below-the-knee amputation (BKA). R2's MDS also indicated diagnoses of neurogenic bladder and obstructive uropathy for which R2 had an indwelling suprapubic urinary catheter. R2's MDS specified he was always incontinent of bowel. R2 was dependent on staff for toileting, showering, and dressing, and required moderate assistance with personal hygiene. He used a wheelchair for mobility and was dependent on staff for repositioning in bed and all transfers. R2's wound/skin care progress note dated 8/4/26, indicated R2 had a stage 4 pressure ulcer on his left buttock with a wound vacuum in place. He also had a stage 3 sacral pressure ulcer and a chronic diabetic left foot ulcer. R2's care plan revised on 5/12/26, identified Enhanced Barrier Precautions (EBP) were initiated on 1/18/26, related to his urinary catheter and pressure ulcers. Staff were directed to: Alcohol-based hand rub in room Educate resident/ family on EHBP and answer any questions or concerns EBP per CDC guidelines EBP signs on doors Garbage in room by exit for PPE removal Gown/gloves prior to high care contact including dressing, bathing/showering, transferring, hygiene, changing linen, changing briefs or toileting, device care, or wound care During an observation on 8/12/26 at 7:16 a.m., there was an isolation caddy with disposable gowns and			F0880			09/04/2026

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F0880 SS = D	Continued from page 31 gloves hanging on R2's door with a sign that indicated R2 required EBP. The hand sanitizer dispenser outside R2's door was empty. A hand sanitizer dispenser inside R2's room near the door was full. R2 was observed eating breakfast in bed. At 7:33 p.m., NA-G arrived at R2's room with a Hoyer lift accompanied by NA-H. Both NA-G and NA-H put on gloves and a disposable gown. NA-G was observed to be wearing her gown open to the front, like a jacket or housecoat. NA-G and NA-H entered R2's room and closed the door. At 7:40 a.m., NA-H opened the door while wearing her gown and gloves, removed her gown and gloves in R2's room, and placed them into the wastebasket in R2's room. She exited the room without performing hand hygiene and returned the Hoyer lift to the storage room across the hall. NA-H stated they had changed R2's brief, emptied his catheter bag, dressed him, and transferred him to the wheelchair with the Hoyer lift. At 7:42 a.m., R2 was observed to be dressed and seated in his wheelchair. NA-G picked up the trash in the room, placed it in R2's wastebasket, and cleaned R2's tray table. NA-G stripped R2's bed and placed the dirty linens in a plastic bag and knotted the top while wearing the same gown which was still open to the front. At 7:48 a.m., NA-G removed her gown and gloves and placed them in R2's wastebasket. She did not perform hand hygiene and did not don another pair of gloves. She removed the liner from the wastebasket, knotted the top of the bag and carried it to the storage room across the hall. NA-G returned to R2's room without performing hand hygiene and gave R2 a washcloth for his face. She put on gloves and carried the sealed bag of dirty linen out of R2's room and placed it in the storage room. She returned to R2's room, removed her gloves, and performed hand hygiene. During an observation on 8/12/26 at 11:14 a.m., NA-G entered R2's room with the Hoyer lift accompanied by NA-F. Both NAs put on a gown and gloves and made up the bed with clean linens. At 11:20 a.m., R2 was transferred to the bed using			F0880			09/04/2026

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F0880 SS = D	Continued from page 32 the Hoyer lift. NA-G told NA-F they needed to “check and change” R2. At 11:23 a.m., NA-F emptied R2’s urinary catheter bag into a plastic bedside urinal and cleaned the tip of the catheter bag with an alcohol wipe. NA-F did not perform hand hygiene or change gloves after emptying the catheter bag or cleaning the tip. At 11:26 a.m., NA-F and NA-G removed R2’s soiled brief, cleaned R2’s skin with disposable wipes, and placed a clean brief on R2. NA-G removed her gloves, performed hand hygiene, and donned new gloves. NA-F kept her gloves on and did not perform hand hygiene. NA-G placed a pillow behind R2’s back and another pillow between his legs. NA-F assisted in adjusting the pillows while wearing the same gloves. At 11:29 a.m., NA-F removed her gown and gloves and left R2’s room with the Hoyer lift. She did not perform hand hygiene. NA-F placed the Hoyer lift in the storage room and proceeded down the hall. During an interview on 8/13/26 at 9:51 a.m., NA-D stated she put on a gown and gloves before entering the rooms of any residents on EBP for whom she would be providing direct cares. She removed the gown and gloves prior to exiting the room and either washed her hands or used hand sanitizer. NA-D stated she changed her gloves and performed hand hygiene in the room whenever her gloves became soiled or when she had performed a more high-risk task such as emptying a catheter bag. She stated the purpose of the gown and gloves was to prevent germs from spreading to other residents on her clothes. She said gowns should be worn with the opening in the back and the ties wrapped around to the front. NA-D stated the facility provided annual training on EBP both online and in-person. During an interview on 8/13/26 at 10:31 a.m., NA-G stated she put on a gown and gloves before entering the room of a resident on EBP if she knew she was going to be providing “hands-on” care to the resident. NA-G said the purpose of the gown was to protect herself and other residents. NA-G stated gowns should be worn with the opening in the back and the strings wrapped around and tied in the front. When asked if she was wearing her gown open to the front on 8/12/26 when providing cares to R2, NA-G stated, “Oh, maybe I did. I’m so sorry.”			F0880			09/04/2026

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F0880 SS = D	Continued from page 33 NA-G confirmed she would change gloves and perform hand hygiene after emptying a urinary catheter or cleaning the tip of the urinary catheter bag. NA-G stated nursing staff had online EBP training every year and the Director of Nursing (DON) had done an in-person training session a couple months ago. During an interview on 8/13/26 at 11:29 a.m., the DON stated in-service training on EBP was conducted for all nursing staff in May and June. Staff were expected to follow EBP according to the CDC guidelines. The DON stated all nursing staff were expected to don a gown and gloves when a resident was on EBP and they were performing high-contact activities including changing linens, bathing, dressing, transferring, changing briefs, performing catheter care, etc. The DON said gowns are to be worn with the opening to the back. The DON stated she expected gloves to be changed and hand hygiene to be performed if gloves become soiled or after providing any high-contact cares, including transferring a resident, changing linens, performing pericare, and emptying a urinary catheter bag. An undated policy titled Enhanced Barrier Precautions received from the facility on 8/13/26, stated it was the facility's policy to implement EBP for the prevention of transmission of multi-drug resistant organisms (MDROs). The policy outlined specific steps related to staff training, EBP initiation, implementation measures, and examples of MDROs of particular concern. An undated policy titled Hand Hygiene received from the facility on 8/13/26, indicated all staff would perform proper hand hygiene procedures to prevent the spread of infection. The policy outlined when hand hygiene was to be performed and which techniques were to be used in specific circumstances.			F0880			09/04/2026
E0025	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency			E0025	E025 – Arrangement with Other Facilities Immediate Corrective Action for the Residents/Situation Cited: The Administrator identified 3 receiving facilities willing to accept residents in the event of an emergency requiring evacuation. Written agreements (MOUs) with the identified		09/04/2026

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E0025	Continued from page 34 plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop and document pre-arranged written agreements with other facilities to receive residents in the event the facility is not able to care for them during an emergency. This has the potential to affect all 80 residents residing in the facility. The facility's Emergency Preparedness Plan (EPP) dated 8/11/25 was reviewed and did not include written agreements with other facilities for receiving residents. During an interview on 8/13/23 at 11:10 a.m., the Administrator confirmed that the facility's EPP did not include written agreements with other facilities to receive residents in the event the facility is not able to care for them during an emergency.			E0025	Continued from page 34 receiving facilities were drafted and executed. The facility emergency preparedness plan was updated to incorporate the executed written agreements. Identification of Other Residents/Areas with the Potential to be Affected: The complete EPP was reviewed against all applicable Appendix Z emergency preparedness requirements to confirm all required elements were in the EPP binder. Any other gaps identified during this review were corrected. Systemic Measures/Prevention Recurrence: A annual review checklist was established for EPP, specifically including a standing item to confirm current, signed written agreements with receiving facilities remain in place and up to date. Monitoring/Quality Assurance to Sustain Compliance: The Administrator/Designee will review the status of all receiving-facility agreements annually and immediately upon any change in receiving-facility participation or contact information. Findings will be reported to the QAPI Committee annually as a part of the standing EPP annual review. Responsible Party: Administrator/Designee Completion Date: 9/4/26		09/04/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/10/26-8/13/26, a licensing survey S5063039 was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with NO citations were issued:			20000			09/04/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2026	
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE , SAINT PAUL, Minnesota, 55108			
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20000	Continued from page 1 H50633621C iQies 232944858 H50633620C iQies 235955852 H50633619C iQies 247464490 H50633618C iQies 257573250 H50633618C iQies 257868783 H50633617C iQies 261389089 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin n/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000			09/04/2026	
20280	Employee Orientation and In-Service Education CFR(s): MN Rule 4658.0100 Subp. 1		20280	Immediate Corrective Action: NA-M completed Dementia Care Training with a		09/04/2026	

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20280	Continued from page 2 Subpart 1. Orientation and initial training. All personnel must be instructed in the requirements of the law and the rules pertaining to their respective duties and the instruction must be documented. All personnel must be informed of the policies of the nursing home, and procedure manuals must be readily available to guide them in the performance of their duties. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 8 staff nursing assistant (NA)-M had completed the required Alzheimer's and dementia care training program. This had the potential to affect all residents in the facility who had an Alzheimer's or dementia diagnosis. Findings include: On 8/13/26 at 8:48 a.m., a request was made to the administrator and the director of nursing (DON) for Alzheimer's and/or dementia care training for eight employees. During an interview on 8/13/26 at 12:05 p.m., the administrator stated they were unable to find Alzheimer's or dementia care training for NA-M who had a start date of 9/9/25. It is the expectation all staff were to receive Alzheimer's and/or dementia care training before working with residents and should also have documentation of the training being completed. A policy related to Alzheimer's and dementia care training was requested, but none was received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The administrator, director of nursing, or designee should develop a system to educate staff and develop a monitoring system to ensure compliance as directed by the written plan of care. The facility should report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations and ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20280	Continued from page 2 follow-up quiz Identification of other residents/areas with the potential to be affected A full audit of all current staff personnel files was conducted to confirm completion of required Dementia Care Training and to identify any other staff with missing or undocumented training. Any additional staff found without completed dementia training completed dementia training with a follow-up quiz. Systemic Measures/Prevention of Recurrence: The facility developed and finalized a written Alzheimer's and Dementia Care Training policy specifying that all staff must complete this training prior to independent resident contact and annually there after Human Resources created a tracking tool to ensure Alzheimer's and Dementia Care training completion Monitoring/Quality Assurance to Sustain Compliance Human Resources Coordinator will audit new hire training completion weekly for the first 90 days after implementation and monthly thereafter. A monthly training compliance report will be reviewed by the Administrator to confirm 100% completion of required Alzheimer's/dementia training for staff. Results will be reported to the QAPI Committee monthly for three months to confirm sustained compliance. Responsible Party: HR Coordinator, which oversight by the Administrator Completion Date: 9/4/26		09/04/2026

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20860	Adequate and Proper Nursing Care; Hands-Feet CFR(s): MN Rule 4658.0520 Subp. 2 F. Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 residents (R58) reviewed for activities of daily living (ADLs) and were dependent on staff for their care. Findings include: R58 R58's quarterly Minimum Data Set (MDS) dated 6/18/26, indicated R58 was cognitively impaired, had no behaviors, did not refuse personal cares, needed maximal assistance with personal hygiene, and was dependent on toileting hygiene and bathing. R58's Clinical Diagnosis report dated 8/12/26, indicated diagnoses of unspecified dementia with mood disturbance, macular degeneration, major depressive disorder, hypertension, and vascular dementia. R58's Activities of Daily Living (ADLs) Care Plan dated 8/12/26, indicated R58 had a self-care deficit related to moderate cognitive impairment and diagnosis of dementia. R58's care plan indicated she was dependent on staff with bathing and personal hygiene. During observation on 8/10/26 at 12:32 p.m., R58 was awake in bed, but did not answer any questions. R58's nails were uneven in length and shape. The nails length ranged between 1 centimeter (cm) to 1.5 cm in length. During interview on 8/11/26 at 11:46 a.m., nursing assistant (NA)-C stated the NAs checked the residents' fingernails and toenails on shower days and cut them as needed. NA-C added the nurses cut the nails of residents with diabetes. During observation and interview on 8/12/26 at 8:21			20860	Nail cares were completed on resident #5 and #58. DON and Nurse Management Team did an audit to make a list of residents requiring specialized nail care due to high risk of conditions and made referral to podiatrist. A shaving audit was performed. Facility has determined all residents have the potential to be at risk. All staff in-service was held 9/1/26 and 9/2/26 on Nail cares and Resident shaving. ADL. policy was reviewed with all staff. A house wide audit was done to see what residents needed razors and POA were notified. On 8/31/29 Facility purchased eclectic razors that have interchangeable heads, so each resident can have their own. The DON or Designees will review residents with high-risk conditions and make appts as needed. Nurse Managers on each floor will monitor ADLs for all residents not able to perform on their own. DON or Designees will QA 5 residents weekly for 1 month and then monthly for 3 months till in compliance. Findings will be brought to QAPI monthly until in compliance. 9/4/26		09/04/2026

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20860	Continued from page 4 a.m., R58 was in the dining room sitting up in her wheelchair. R58’s clothes were clean, but her nails were still long, uneven and had black matter underneath. During interview on 8/12/26 at 8:36 a.m., licensed practical nurse (LPN)-B verified R58’s fingernails were long, uneven, and had black matter underneath. LPN-B stated she would try to cut them, but most likely, R58 would refuse. During interview on 8/13/26 at 9:51 a.m., director of nursing (DON) stated the residents’ nails needed to be cut on their shower day. DON stated NAs were supposed to attempt cutting residents nails, and if they failed, NAs needed to report this failure to the nurses. The nurses also needed to reapproach to try and cut the residents’ nails. DON stated the facility had ordered different nail care supplies and would try to file F58’s fingernails. DON stated long nails get dirty and they were an infection control issue. Requested a facility’s policy about Nail Care but none was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nail care for dependent residents. The director of nursing or designee could re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's quality assurance performance improvement (QAPI) committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20860			09/04/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 11, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Anthony Park Home, 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			09/03/2026

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.

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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: 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. Building Info: ST ANTHONY PARK HOME is a three-story building with a basement. The St Anthony Park Home was constructed at three different times. The original building was built in the 1900's, 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. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building.			K0000			09/03/2026

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K0000 Bldg. 01	Continued from page 2 The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			09/03/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and			K0918	K918 – Electrical Systems – Essential Electric System Maintenance and Testing Corrective Action Taken: The Maintenance Director performed the battery specific gravity/conductance testing on the emergency generator battery system. The facility’s emergency generator diesel fuel supply was sampled and submitted for annual fuel quality testing in accordance with NFPA 110. The battery specific gravity/conductance testing was added to TELS to be performed monthly. The diesel fuel supply test was added to TELS to be completed annually. Results were filed in the facility’s Life Safety Maintenance folder Measures to Prevent Recurrence: The facility's preventative maintenance (PM) schedule was revised to include battery specific gravity/conductance testing and annual fuel quality testing and this was built into TELS with automatic reminder notifications for the Maintenance Director. The generator service contract was reviewed/updated with the vendor to confirm annual fuel testing are included as contracted scope of		09/04/2026

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K0918 SS = F Bldg. 01	Continued from page 3 staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.7.1 and 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 8/11/2026, at 11:50 AM, it was revealed by a review of available documentation, the facility was not testing the batteries for the Emergency Generators for specific gravity or conductance and had not completed the annual fuel testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0918	Continued from page 3 work going forward. Monitoring of Ongoing Compliance: Completed test records will be reviewed by the Maintenance Director and initialed by the Administrator/Designee monthly Results will be reported to the QAPI Committee quarterly for a minimum of two quarters to confirm sustained compliance Responsible Party: Maintenance Director, with the oversight by the Administrator Completion Date: 9/4/26		09/04/2026
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			K0363	K363 – Corridors Doors Corrective Action Taken The third floor smoke door by the elevator was immediately corrected and repaired so the doors positively latch on the first attempt Measures to Prevent Recurrence: A facility-wide inspection of all corridor and smoke/fire barrier doors was conducted to identify and correct any additional doors with latching, closing, or alignment deficiencies. Door latching and self closing device function was added as a documented monthly item on the Life Safety/fire door inspection rounds in TELS Maintenance staff were re-educated on proper adjustment of door closers and latching hardware and on the requirement to report any non-latching door as an immediate work order. Monitoring of Ongoing Compliance		09/03/2026

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K0363 SS = D Bldg. 01	Continued from page 4 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 walls per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.7.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 8/11/2026, at 12:40 PM, it was revealed by observation that the fire doors just off the elevator on the 3rd floor failed to latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0363	Continued from page 4 Maintenance staff will perform and document monthly functional testing of all corridor and fire/smoke doors, confirming positive latching, closing or alignment deficiencies. If warranted, corrective action will be taken immediately. Monthly door inspection logs will be reviewed by the Maintenance Director and reported to QAPI Committee quarterly for a minimum of two quarters to confirm sustained compliance Responsible Party: Maintenance Director Completion Date: 9/4/26		09/03/2026
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas			K0923	K923 – Gas Equipment – Cylinder and Container Storage Corrective Action Taken The free-standing oxygen cylinder in the 1st floor oxygen storage room was immediately secured in a proper cylinder stand Full and empty cylinders in the oxygen storage room were physically segregated and clearly labeled Full/Empty to eliminate confusion Measures to Prevent Recurrence: Signage was posted in the storage room designating dedicated, labeled areas for full and empty cylinders. Nursing and maintenance staff who handle oxygen cylinders were re-educated on proper securement and fully/empty segregation requirements.		09/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE , SAINT PAUL, Minnesota, 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
K0923 SS = D Bldg. 01	Continued from page 5 with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to construct a storage space that is of non-combustible materials in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 11.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 8/11/2026, at 12:55 PM, observations and staff interview revealed that the 1st floor oxygen storage room, there was a free-standing tank, not properly secured and the bottles were not properly separated to designate the full cylinders from the empty cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0923	Continued from page 5 Monitoring of Ongoing Compliance: The oxygen storage room will be audited weekly x4 and will be added to the PM Schedule/TELS to audit monthly Any unsecured cylinder or segregation lapse identified will be corrected immediately and documented as a variance Monitoring results will be reported to the QAPI Committee quarterly for a minimum of two quarters to confirm sustained compliance Responsible Party: Maintenance Director, with support from Nursing Leadership Completion Date: 9/4/26		09/04/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 17, 2026

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

RE: CCN: 245063
Cycle Start Date: September 17, 2026

Dear Administrator:

On September 17, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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September 17, 2026

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

Re: Reinspection Results
Event ID: 284EF6-H2

Dear Administrator:

On September 17, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 13, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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