Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 10, 2025

Administrator
St. Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

Re: Reinspection Results
Event ID: 9IWG12

Dear Administrator:

On May 21, 2025, 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 April 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically Delivered
June 10, 2025

Administrator
St. Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

RE: CCN: 245267
Cycle Start Date: April 10, 2025

Dear Administrator:

On May 21, 2025, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 28, 2025

Administrator
St. Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

RE: CCN: 245267
Cycle Start Date: April 10, 2025

Dear Administrator:

On April 10, 2025, 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 July 10, 2025 (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 October 10, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	C 04/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/7/25 through 4/10/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/7/25 through 4/10/2025, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52672711C/MN112077 H52672755C/MN002026 H52672505C/MN111508 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

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

Electronically Signed | 05/07/2025

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

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 residents (R66) observed with medications at bedside. Findings include: R66's admission minimum data set (MDS) dated 2/20/25, indicated she had intact cognition, did not refuse care or medications and had the following diagnoses: cancer, malnutrition, asthma, chronic obstructive pulmonary disease and/or chronic lung disease. The MDS further indicated R66 took antipsychotic, antianxiety, antidepressant, opioids and required oxygen therapy. R66's order summary report printed on 4/10/25, included antianxiety medications, antidepressant medications, antipsychotic medications and narcotic pain medications which can cause blurriness, dizziness and sedation. Additionally, R66 required nebulizer breathing treatments 4	F 554	1. R66 has discharged from facility. 2. Residents who utilize nebulizers were identified and assessed for the appropriateness of self-administration of nebulizer medication. Care plans were also reviewed and revised as necessary. 3. Facility policy on Self Administration of Medications was reviewed. Education regarding Self administration of medication completed with licensed nursing staff and TMAs. 4. Five (5) residents with nebulizers will be audited weekly x four (4) weeks to ensure compliance. QAPI Committee will review audit results and recommend continued audit schedule.	5/19/25

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F 554	Continued From page 2	F 554		

times throughout the day and the use of supplemental oxygen. The order summary lacked documentation of an order for self-administration of medications (SAM).

R66's medication administration record (MAR) dated 4/1/2025-4/30/2025, indicated R66 had been administered all scheduled doses for the month of April. However, the MAR lacked documentation of an order for self-administration of medications.

R66's care plan lacked information regarding self-administration of medications.

During observation on 4/8/25 at 8:49 a.m., R66 was in bed resting quietly with eyes closed with her bedside table over the right side of the bed. To her immediate left was another facility bed not in use. At the end of her bed was a walker and a wheelchair. Just inside the door to the immediate right, approximately 8 feet from R66, was shower chair covered with a black and white rug. On top of the rug was a white nebulizer machine. Connected to the machine was green tubing connected to a nebulizer cup. The nebulizer cup was approximately two thirds full of clear liquid. A nebulizer solution cap and empty vial was next to the neb machine.

During interview on 4/8/25 at 9:17 a.m., registered nurse (RN)-C stated she had not yet given R66 her morning medications. RN-C picked up the nebulizer cup and confirmed the nebulizer cup was two thirds full and stated it was probably the neb treatment from the night before. RN-C stated R66 wouldn't even be able to reach it where it was located so far from her bed. RN-C went on to say she was unclear if R66 could

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F 554	Continued From page 3 administer her own medications. During interview on 4/8/25 at 3:46 p.m., registered nurse manager (RNM) stated if a resident wished to administer their own meds they would need to be assessed upon admission and with any significant change of condition. RNM stated the assessment for a nebulizer would include the resident demonstrating they could hold the neb cup during administration and were able to remove it when it was completed. RNM stated without a SAM in place she expected the nursing staff to prepare the medication and stay with the resident during administration. RNM stated if a resident had a SAM order a nebulizer could be left with the resident to self-administer, however, the nurse would be required to come back and complete a respiratory assessment when the nebulizer was completed. RNM reviewed R66's electronic medical record and stated R66 did not have a SAM assessment or an order to self-administer medications and a full neb cup should not have been left in her room to self-administer. Facility policy titled Self Administration of Medications with a last review date of 10/14/24 indicated the following: A resident may only self-administer medications after the facility's interdisciplinary team (IDT) has determined which medications may be self-administered safely. When determining if self-administration is clinically appropriate for a resident the IDT consider the residents physical capacity appropriately administer; the resident's capability to follow directions; the resident's comprehension of instructions for the medications they are taking; and the resident's ability to ensure medication is stored safely and securely. The policy went on to	F 554		

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F 554	Continued From page 4 indicate all nurses and aides are required to report to the charge nurse any medication found at the bedside not authorized for bedside storage and the care plan must reflect resident self-administration and storage arrangements for such medications.	F 554		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		5/19/25

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F 656	Continued From page 5 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to update a care plan 1 of 1 residents (R66) reviewed for a declining resident. Findings include: R66's minimum data set (MDS) dated 2/20/25, indicated she had intact cognition, did not refuse care or medications and had the following diagnoses: cancer, malnutrition, asthma, chronic obstructive pulmonary disease and/or chronic lung disease. The MDS further indicated R66 was independent with eating, personal hygiene, toileting, dressing, mobility, transfers and received hospice services. R66's face sheet indicated R66 was contracted Hospice of the Midwest to receive hospice cares and services. R66's care plan indicated R66 had a self-care	F 656	1. R66 has discharged from facility. 2. All hospice resident□s ADL care plans have been reviewed and corrected, as needed. 3. Facility policy regarding Care Plan Revisions upon Status Change was reviewed. Education was completed with all nursing staff regarding updating care plans and Kardex information. 4. Five (5) residents will be audited weekly x four (4) weeks to ensure compliance. QAPI Committee will review audit results and recommend continued audit schedule.	

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F 656	Continued From page 6 deficit and required assistance with activities of daily living (ADL's) due to terminal lung cancer/respiratory failure. The care plan also indicated R66 received hospice services, and the nurse manager was the designated facility interdisciplinary team (IDT) member to collaborate with hospice to ensure the needs of R66 were being met. R66's order summary report printed 4/10/25 indicated R66 took antidepressant medication with potential side effects of dizziness, fatigue, and anxiety; antipsychotic mediations with potential side effects of blurred vision, postural hypotension(a sudden drop in blood pressure that occurs when a person changes from a lying or sitting position to standing), sedation, confusion, and restlessness; Gabapentin with potential side effects of drowsiness, dizziness, sedation and blurred vision; an opioid medication with potential side effects of dizziness, delirium, over sedation and changes in mental status. R66's medication administration record (MAR) for April 2025 indicated R66 took the following scheduled medications: 100mg quetiapine at bedtime for anxiety, 0.5mg lorazepam twice a day for shortness of breath, 400mg gabapentin three times a day for pain, 30mg morphine three times a day for pain; and the following as needed medications: 15mg morphine tablet every two hours as needed for pain, and 0.75 ml (20mg/ml) every two hours as needed for shortness of breath. The MAR also indicated R66 had not missed any scheduled medications in April 2025 and had been administered as needed morphine three times between April 1st and April 10th, 2025.	F 656		

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F 656	Continued From page 7	F 656		

R66's bedside Kardex dated 4/9/2025 indicated R66 was able to take showers/baths independently with no staff oversight, was able to toilet independently, and was able to transfer independently with no staff oversight.

During observation on 04/08/25 at 3:28 p.m. R66 was lying in bed, eyes closed, deep even breathing noted; dressed in light colored top and dark bottoms and did not respond to knocking on door from staff.

During observation on 04/09/25 7:28 a.m. R66 was lying in bed on her left side with eyes closed. R66 was wearing same light-colored top and dark bottoms as previous day. R66's hair pulled up into bun on top of head and had a greasy appearance.

During interview on 04/09/25 at 10:54 a.m. registered nurse (RN)-C stated R66 was very weak, and the aides had been providing toileting cares to include changing soiled incontinent briefs, assisting with bathing or showering and could no longer dress herself or change her clothes. RN-C could not locate any documentation on R66's bathing record and stated she had been previously independent but was now dependent on staff for assistance with 'basically everything'. RN-C stated R66 did not have a hospice aide to assist with personal cares and she had been updated by the nurse manager that R66 was declining, and staff would have to start doing more cares for her.

During interview on 04/09/25 at 10:57 a.m. certified nursing assistant (CNA)-C stated R66 received assistance with toileting, bathing and sometimes repositioning in bed. CNA-C stated

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F 656	Continued From page 8	F 656		

R66 had been able to do her own shower previously but had been steadily declining and now needed assistance for all her personal cares. CNA-C stated staff would look to the Kardex for instructions on how to care for residents. CNA-C opened R66's Kardex, stated it was incorrect and did not reflect the cares R66 was currently needing.

During observation on 04/10/25 at 11:07 a.m. R66 was observed lying in bed with her eyes closed, wearing what appeared to be the same light-colored top and dark bottoms she had been wearing the previous two days. R66's hair was unkept and had stringy strands hanging loose from a ponytail on the top of her head. R66 did not respond to verbal stimulation.

During interview on 04/10/25 at 11:51 a.m. registered nurse case manager (NM)-C stated care plans and Kardex's were updated with changes after a fall, beginning or ending therapy, hospitalizations or any significant change of condition. NM-C stated she was ultimately responsible for updating resident care plans and the Kardex. NM-C reviewed R66's care plan and stated it had not been updated. R66 was not independent with bathing or toileting, she required oversight. NM-C stated R66 had been steadily declining and agreed the care plan should have been updated to reflect her increased need of assistance with all personal cares.

During interview on 04/10/25 at 12:35 p.m. director of nursing (DON) stated care plans were reviewed by using an IDT approach and depending on the topic it could be updated by the MDS nurse or the NM. DON stated care plans were updated with new therapies, after a fall,

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

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F 656	Continued From page 9	F 656		

hospitalization, or a change of condition. DON stated the process would be the same for all residents regardless of their hospice designation. DON acknowledged R66 had been declining and stated she was aware she required more assistance. DON went on to say it was her expectation care plans were updated as soon as a change was identified. This was important to ensure all resident care needs were met.

Facility document titled Care Plan Revisions Upon Status Change with a created date of 9/26/2023 indicated the purpose of the procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The policy indicated the following:
1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.
2. Procedure for reviewing and revising the care plan when a resident experiences a status change:
a. upon identification of a change in status, the nurse will notify the MDS coordinator, the physician and the resident representative
b. the MDS coordinator and the IDT will discuss the resident condition and collaborate on intervention options
c. the care plan will be updated with the new or modified interventions
d. staff involved in the care of the resident will report resident response to new or modified interventions
e. care plans will be modified as needed by designated staff
f. the unit manager or other designated staff will communicate care plan interventions to all staff involved in the resident's care

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F 656	Continued From page 10 g. the designated staff member will conduct an audit on all residents experiencing a change in status at the time of the change in status is identified to ensure care plans have been updated to reflect current resident needs	F 656		
F 677 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; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provided nail care for 1 of 4 residents (R15) reviewed for dependent activities of daily living (ADLs). Findings include: R15's PPS 5 day scheduled Minimum Data Set (MDS) assessment dated 2/21/25, included R15 was admitted 2/14/25 and had moderate cognitive impairment. R15 had impairment on one side and was dependent with bathing. Personal hygiene assessment was not recorded on the MDS submission. R15's undated care plan included a focus of being at risk for excessive bruising and bleeding due to use of coumadin (a blood thinner) with an intervention to remind R15 to use extra caution when shaving. The care plan included R15 had a self care deficit and required assistance with ADLs due to weakness, impaired mobility and having multiple disease processes and had an intervention of needing assistance with all ALDs.	F 677	1. R15 did not experience any adverse health events or negative outcomes related to nail care, R15□s nails were trimmed per resident preference on 4/8/25. 2. Residents who require assistance with nail care were audited to ensure their nails were trimmed per preference. Care plans were reviewed and revised as necessary. 3. Policy regarding Activities of Daily Living was reviewed. Nursing staff have been educated on offering nail care and appropriate documentation of acceptance and refusals. 4. DON or Designee will audit five (5) residents weekly x four (4) weeks to ensure compliance. QAPI committee will review the audit results and recommend continued audit schedule.	5/19/25

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F 677	Continued From page 11 On 4/7/25 at 2:52 p.m., R15 was observed to have fingernails that extended past the tips of his fingers on both hands. Fingernails on his dominant left hand were irregular. During interview on 2:52 p.m., R15 stated he does not like his fingernails being as long as they are and that they sometimes get caught on his sheets when he is in bed. R15 stated he preferred to be clean shaven, but is unable to shave at this time due to not having a razor he can use. During observation and interview on 4/8/25 at 11:07 a.m., R15's fingernails remained long and irregular and face unshaven. Facial hair was approximately ½ to 1 inch in length. R15 stated he typically would shave his head in addition to his face. R15 stated he spoke with someone at the facility 2 to 3 weeks ago and they said they would get him an electric razor to use. He did not ever receive the electric razor. During interview on 4/8/25 at 11:14 a.m., nursing assistant (NA)-A stated grooming assistance should be completed every morning. A nurse should be updated if a resident refused. During interview on 4/8/25 at 11:35 a.m., registered nurse (RN)-A stated nail care should be completed on bath days or as needed and diabetic residents needed to have nail care completed by a nurse. During interview on 4/8/25 at 4:42 p.m., nurse manager (NM)-D stated fingernail care should have been completed on a resident's bath day but could have been completed another time if the	F 677		

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F 677	Continued From page 12 resident refused on bath day. NM-D stated assistance with shaving was available and an electric razor was available if the resident did not have access to one. NM-D confirmed R15 did have long nails that extended about 0.3 centimeters (cm) past his fingertip. NM-D confirmed there was occasionally dark matter visible under the fingernails and the staff should have been assisting R15 with cleaning his nails daily and after meals. NM-D confirmed R15 was on blood thinners and recently had high lab values which put him at a greater risk for bleeding. NM-D stated R15 was at increased risk for bleeding and infection due to his longer fingernails. During interview on 4/9/25 at 2:31 p.m., the director of nursing (DON) stated nail care should have been completed on bath day. A resident should have been reapproached if they refused and a progress note should have been completed. The DON confirmed she was informed R15's fingernails were long and in need of nail care. The DON state routine nail care was important to prevent the nails from getting long and possibly getting caught on something, torn or infected. Facility policy titled Activities of Daily Living dated 10/7/24, included ADLs included bathing, grooming and dressing. The facility would provide necessary services for residents who were unable to complete these tasks.	F 677		

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F 677	Continued From page 13	F 677		
F 684 SS=D	X Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow current physician orders and parameters for 2 of 5 residents (R28, R61) reviewed for medications. Findings include: R28's quarterly Minimum Data Set (MDS) dated 2/12/25, included R28 had moderate cognitive impairment. R28 had diagnoses of gastroparesis (a disease of the digestive system), malnutrition, fecal impaction (a blockage of stool in the intestine). R28's last signed physician orders dated 3/4/25, included an order for prochiorperazine maleate (a medication to treat nausea and vomiting) 10 mg by mouth every 5 hours as needed for nausea and vomiting, polyethylene glycol (a medication to treat constipation) 17 grams by mouth one time a	F 684	1. R28 and R61 were not affected by the alleged deficient practice. Residents were receiving medications per provider orders. Orders were reviewed and updated, and clarified as needed. 2. Residents who receive services from this provider were identified and orders were reviewed and updated as needed. 3. Policy regarding Medication Administration was reviewed. Licensed Nurses, medical records and Northern Lights provider have been educated on process to reconcile medications. Order summary reports for all residents serviced by this provider were reviewed and updated, as needed, and signed by provider. DON or Designee will audit five (5) residents weekly x four (4) weeks to ensure compliance. QAPI committee will review the audit results and recommend	5/19/25

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F 684	Continued From page 14 day, and metoprolol tartrate 25 mg by mouth twice a day with instructions to hold the medication if systolic blood pressure was less than 100. R28's medication administration record (MAR) for April included record of medication being given different than the most recent provider orders. Administration included prochiorperazine maleate 10 mg by mouth every 8 hours for gastroparesis, polyethylene glycol (a medication to treat constipation) 17 grams by mouth two times a day, and metoprolol tartrate 25 mg by mouth twice a day without instructions to hold the medication. R28's hospital discharge orders with admission date 11/21/24, included order changes for polyethylene glycol 17 grams two times a day, prochlorpherazine 10 mg every 8 hours for gastroparesis, and metoprolol tartrate 25 mg twice a day without instructions to hold the medication. R28's MAR for February, March and April reviewed and failed to include documentation of blood pressure readings. During interview on 4/10/25 at 9:56 a.m., nurse manager (NM)-C confirmed the last signed physician orders do not match the MAR and what was currently being given. NM-C stated the facility takes all written orders, which include hospital discharge orders and process them as current orders. NM-C stated clarification would be requested from the hospital or nurse practitioner if there were questions or discrepancies. NM-C stated it was not practice to compare the most recent signed orders from the regulatory visits with the current MAR. The facility would review	F 684	continued audit schedule.	

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F 684	Continued From page 15 the "plan" section to look for new orders. R61's significant change MDS dated 1/10/25, included R61 was cognitively intact. R61's diagnoses included neuromyelitis optica (a disorder of the nervous system which can lead to weakness) and diabetes. R61's last signed physician orders dated 2/3/25, included an order for tacrolimus (a medication to prevent rejection of an organ after transplant) 1.5 mg by mouth two times a day and 2 mg at bedtime for kidney transplant, hydralazine (a medication to treat high blood pressure) 100 mg three times a day with instructions to hold for mean arterial pressure (MAP) <65, and carvedilol 12.5 mg by mouth twice a day with instruction to hold if MAP was <65. R61's MAR for April included record of medication being given different than the most recent provider orders. Administration record included tacrolimus 2.5 mg twice a day. Hydralazine was administered 100 mg three times a day with instructions to hold for MAP <65, however blood pressure was recorded instead of MAP. Carvedilol was administered 12.5 mg by mouth twice a day with instruction to hold if MAP is <65, however no vitals (blood pressures) were recorded. R61's hospital discharge orders with encounter date 11/21/24, included an order change for tacrolimus 2.5 mg twice a day. R61's MAR for February, March and April reviewed and failed to include documentation of MAP and pulse prior to administration of medication.	F 684		

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F 684	Continued From page 16 During interview on 4/9/25 at 10:01 a.m., licensed practical nurse (LPN)-A stated parameters and instructions for giving mediation was listed on the MAR. After reading R61's orders for carvedilol and hydralazine with parameters, LPN-A stated she would check the pulse if the instructions stated to hold if <65 and would not give the medication if the pulse was below 65. During interview on 4/9/25 at 10:25 a.m., nurse manager (NM)-C stated she had never seen MAP as a parameter in a nursing home before and she was unsure if the staff would know how to calculate MAP. NM-C stated an order with instructions to check MAP should have been followed up on because it is not something that should have been used in a nursing home. During interview on 4/9/25 at 10:23 a.m., registered nurse (RN)-B stated she would check a heart rate for an order that instructed to check MAP and hold if <65 and not give the medication if it was below 65. During interview on 4/10/25 at 11:18 a.m., medical director (MD) stated a typical parameter for carvedilol and hydralazine would be to measure the heart rate and blood pressure. MD stated the facility did not calculate MAP. He stated a resident could be at increased risk for falls if a blood pressure medication was given outside of parameters. During interview on 4/10/25 at 12:33 p.m., CP confirmed she reviewed ordered parameters to ensure they are standard parameters during her monthly med reviews. CP acknowledged she failed to identify the discrepancies during the	F 684		

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F 684	Continued From page 17 monthly reviews. CP stated blood pressure and heart rate are often monitored when a resident is on carvedilol. During interview on 4/9/25 at 2:41 p.m., director of nursing (DON) confirmed the last signed physician orders for R21 did not match what was being given by the facility. DON confirmed R61 tacrolimus order was different on the last signed physician orders and what was being given by the facility. DON confirmed medication parameters should have always been followed and if there was a question, a provider should have been contacted for clarification. DON confirmed checking and documenting a blood pressure would not be the same as checking and documenting a MAP. The DON confirmed the facility was not following their policy and procedure for reviewing signed physician orders to recognize discrepancies. Facility policy for medication orders dated 10/14/24, included to enter new orders onto the MAR. The nurse should verify new orders with the current attending physician before the medication is administered if it was unclear.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688		5/19/25

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F 688	Continued From page 18 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) exercises for 1 of 1 residents (R61) reviewed for mobility. Findings include: R61's significant change Minimum Data Set (MDS) dated 1/10/25, included diagnoses of neuromyelitis optica (inflammation of the nerves of the eye and spinal cord which may cause vision loss and muscle weakness), diabetes, encephalopathy (a disorder of the brain which may cause confusion, memory loss and personality changes). R61's MDS included she was dependent for dressing, eating and oral hygiene. R61's undated care plan, included R61 required assistance with activities of daily living (ADLs) due to impaired or decreased mobility, weakness and multiple disease processes. Interventions included to assist with positioning and mobility as needed. R61's care plan failed to include specific ROM exercises. R61's care conference note dated 3/19/25, included R61's family requested therapy for ROM	F 688	1. R61 was assessed for ROM program by therapy on _____4/9/25__ and care plan was adjusted accordingly. 2. Residents who require range of motion exercises per therapy recommendations were identified and care plans reviewed and revised as necessary. 3. Prevention of Decline in Range of Motion Policy was reviewed. Nursing staff and IDT educated on communication with therapy and ROM program. 4. DON or Designee will audit five (5) residents weekly x 4 weeks to ensure compliance. QAPI committee will review the audit results and recommend continued audit schedule.	

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F 688	Continued From page 19 due to stiffness. R61's medical record indicated she was discharged from physical therapy on 11/18/24 and occupational therapy on 12/19/24. No other referral order was provided. During interview on 4/8/25 at 11:14 a.m., nursing assistant (NA)-A stated ROM instructions would be included on a resident's care sheet if they were ordered. During interview on 4/9/25 at 7:53 a.m., NA-B stated ROM exercises would be documented in a resident's chart if they were completed. During interview on 4/9/25 at 7:56 a.m., nurse manager (NM)-C stated a therapy referral would usually be made if a resident had a change in condition, a decrease in ADL ability, or after a hospitalization. NM-C stated a referral for therapy would be made if a family requested it. NM-C confirmed there had not been a referral for therapy since the last care conference. NM-C confirmed the family did request a referral for therapy for ROM exercises. NM-C stated it would typically be nursing who followed up on a requested from family for therapy. During interview on 4/9/25 at 2:34 p.m., director of nursing (DON) stated a referral for therapy should have been completed after the family requested an evaluation. The DON stated the referral should have been made within 2-3 business days of the care conference and family request. The DON confirmed ROM exercises should have been on the care plan or Kardex. The DON stated ROM was important to prevent pain, pressure ulcers and contractures.	F 688		

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F 688	Continued From page 20 Facility policy titled Prevention of Decline in Range of Motion dated 10/14/24, included a licensed nurse will assess a resident's range of motion on admission, quarterly and upon significant change. Residents would be referred to therapy for a focused range of motion as appropriate.	F 688		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		5/19/25

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F 756	Continued From page 21 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist (CP) failed to identify and report irregularities related to resident parameters for 2 of 2 residents (R28, R61) reviewed for physician ordered parameters. Findings Include: R28's quarterly Minimum Data Set (MDS) dated 2/12/25, included R28 had moderate cognitive impairment. R28 had diagnoses of gastroparesis (a disease of the digestive system), malnutrition, fecal impaction (a blockage of stool in the intestine). R28's last signed physician orders dated 3/4/25, included an order for metoprolol tartrate 25 milligrams (mg) by mouth twice a day with instructions to hold the medication if systolic blood pressure was less than 100. R28's medication administration record (MAR) for April included record of medication being given without documentation of blood pressure having been checked prior to administration. The order on the MAR included metoprolol tartrate 25 mg by mouth twice a day without instructions to hold the	F 756	1. R28 and R61□s orders were reviewed and are up to date. 2. Residents who receive blood pressure medications have had physicians orders reviewed for compliance. 3. Policy regarding Medication Regimen Review was reviewed. Nursing staff and pharmacy consultant educated on medication orders and parameters. 4. DON or Designee will audit five (5) residents weekly x 4 weeks to ensure compliance. QAPI committee will review the audit results and recommend continued audit schedule.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	C 04/10/2025

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

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F 756	Continued From page 22 medication. R28's previous six months of pharmacy reviews failed to identify blood pressure parameter was not being followed. R61's significant change MDS dated 1/10/25, included R61 was cognitively intact. R61's diagnoses included neuromyelitis optica (a disorder of the nervous system which can lead to weakness) and diabetes. R61's last signed physician orders dated 2/3/25, included an order hydralazine (a medication to treat high blood pressure) 100 mg three times a day with instructions to hold for mean arterial pressure (MAP) < 65, and carvedilol 12.5 mg by mouth twice a day with instruction to hold if MAP was < 65. R61's MAR for April included record of medication being given without documentation of provider ordered parameters. Administration record included hydralazine 100 mg three times a day with instructions to hold for MAP < 65, however blood pressure was recorded instead of MAP. Carvedilol was administered 12.5 mg by mouth twice a day with instruction to hold if MAP is < 65, however no vitals (blood pressures) were recorded. R61's previous six months of pharmacy reviews failed to identify MAP parameter was not being followed nor did they recommend reviewing the parameter for a standard nursing home parameter. During interview on 4/9/25 at 10:25 a.m., nurse manager (NM)-C stated she had never seen MAP	F 756		

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F 756	Continued From page 23 as a parameter in a nursing home before and she was unsure if the staff would know how to calculate MAP. NM-C stated an order with instructions to check MAP should have been followed up on because it is not something that should have been used as a parameter in a nursing home. During interview on 4/9/25 at 2:41 p.m., director of nursing (DON) confirmed medication parameters should have always been followed and if there was a question, a provider should have been contacted for clarification. DON confirmed checking and documenting a blood pressure would not be the same as checking and documenting a MAP. During interview on 4/10/25 at 11:18 a.m., medical director (MD) stated a typical parameter for carvedilol and hydralazine would be heart rate and blood pressure. MD stated the facility would not typically calculate MAP. He stated a resident could be at increased risk for falls if a blood pressure medication was given outside of parameters. During interview on 4/10/25 at 12:33 p.m., CP confirmed she reviewed ordered parameters to ensure they are standard parameters during her monthly medication reviews. CP acknowledged she failed to identify the discrepancy in parameters order and what was being documented by the facility. CP stated MAP was not a standard parameter for a nursing home and a more common parameter would be to check blood pressure and heart rate for a resident on carvedilol prior to administration.	F 756		
F 867 SS=F	QAPI/QAA Improvement Activities	F 867		5/19/25

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F 867	Continued From page 24 CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to	F 867		

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F 867	Continued From page 25 prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms	F 867		

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F 867	Continued From page 26 that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance Assessment and Performance Improvement Plan (QAPI) committee effectively sustained ongoing	F 867	1. Although ongoing compliance from the QAPI committee regarding previous surveys was not sustained, Residents present during the survey did not	

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F 867	Continued From page 27 compliance related to repeat citations from past surveys in regards to quality of care, care plans and self-administration of medications (SAM) which were also identified during this survey. This had the potential to effect all 74 residents residing in the facility. Findings include: Review of the facility CASPER Report dated 3/17/2025, identified the facility was cited F684 for quality of care, F656 development/implementation of comprehensive care plans, and F554 SAM during the survey exited 3/7/2024. See F684: Based on interview and document review, the facility failed to follow current physician orders and parameters for 2 of 5 residents (R28, R61) reviewed for medications. See F656: Based on observation, interview and record review, the facility failed to ensure a care plan was developed and maintained to ensure appropriate care was provided for 1 of 1 residents (R66) reviewed for increased care needs for a declining resident. See F554: Based on observation, interview and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 residents (R66) observed with medications at bedside. The facility's QAPI meeting minutes dated 1/27/25, 2/24/25, and 3/24/25, lacked ongoing data related to the above repeat citations.	F 867	experience any adverse health events or negative outcomes. 2. Policy regarding QAPI process was reviewed. 3. New section has been added to QAPI form to review any previous alleged deficient practices, audit results and recommendations for monitoring thereafter. 4. IDT team was educated regarding this process.	

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F 867	Continued From page 28 On 4/10/25 at 1:45 p.m., the administrator confirmed the facility had not been tracking previous compliance with surveys, and have recently became aware and began to form a plan to monitor and maintain compliance in the future. The QAPI policy last reviewed 1/11/25, identified the facility will demonstrate the development, implementation, and evaluation of corrective actions or performance improvement activities.	F 867		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 28, 2025

Administrator
St Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

Re: State Nursing Home Licensing Orders
Event ID: 9IWG11

Dear Administrator:

The above facility was surveyed on April 7, 2025, through April 10, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00522	A. BUILDING: _____ B. WING _____	C 04/10/2025

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2 000	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 4/7/2025 through 4/10/2025, a licensing survey 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	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52672711C/MN112077 H52672755C/MN002026 H52672505C/MN111508 NO citations were issued. 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 <https://www.health.state.mn.us/facilities/regulation/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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.	2 302		5/19/25

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2 302	Continued From page 3 (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided written or electronic information regarding training staff had received for Alzheimer's/dementia care. This had the potential to affect all 74 current residents, family members, and consumers. Findings include: Review of staff training records verified Alzheimer's Disease and Related Disorders was completed by staff providing care for residents with Alzheimer's/dementia. However, documents lacked evidence consumers were made aware this training had occurred. During interview on 4/10/25 ay 1:45 p.m., administrator stated there was no written or electronic notification provided to consumers with a description of the dementia training program, the categories of employees trained, the frequency of training, or the basic topics covered. The administrator acknowledged the facility needed to provide consumers with written or electronic information regarding training staff had received for Alzheimer's/dementia care. SUGGESTED METHOD OF CORRECTION: The facility could review the Minnesota statutes for dementia training and develop a written or electronic means of communication for the dementia training to the consumer. The facility could implement the communication into their	2 302	Corrected	

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2 302	Continued From page 4 admission process. The facility could then create and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening and testing was completed for 2 of 5	21426	Corrected	5/19/25

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	00522	A. BUILDING: _____ B. WING _____	C 04/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 5 residents (R3, R61) and 1 of 5 staff members (Dining room supervisor (DRS)) reviewed for TB testing. Findings include: The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis in Health Care Settings, 2005, directed that all residents and staff must receive a baseline TB screening should consist of an assessment for TB risk factors and history, assessment for current symptoms of active TB, and testing for the presence of infection with mycobacterium tuberculosis. R3's quarterly Minimum Data Set (MDS) dated 1/3/25, included an admission date of 4/19/24. R3's had diagnoses of diabetes and paraplegia (paralysis of lower body). R3's medical administration record for April 2024, included an administration date of 4/19/24 for the Step 1 TB screening. Step 1 TB screening was scheduled to be read on 4/22/24, but was not read until 4/24/24. R61's significant change MDS dated 1/10/25, included an admission date of 11/29/24. R61's diagnoses included neuromyelitis optica (a disorder of the nervous system which can lead to weakness) and diabetes. R61's chest x ray dated 10/20/24, failed to include interpretation of results for TB status. Employee roster dated 4/7/25, included a start date of 12/20/24 for dining room supervisor (DRS)-A.	21426		

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21426	Continued From page 6 DRS-A baseline TB screening tool was completed 4/8/25. TB screening included a Step 1 tuberculin skin testing (TST) given 4/8/25. No additional results or test provided. During interview on 4/9/25 at 11:07 a.m., infection preventionist (IP) confirmed R3's step 1 TB test was not read within the 48-72 hour time frame required. IP confirmed R61's chest xray did not include interpretation of results for tuberculosis screening. IP confirmed DRS-A did not have a complete TB testing series. IP confirmed these were not in compliance with TB screening requirements. During interview on 4/9/25 at 11:07 a.m., director of nursing (DON) confirmed it was important to complete TB screening and testing so the facility would be aware of residents and staff who were positive so treatment could be started immediately. Facility policy for TB testing included to complete all screening and testing required by the CDC. SUGGESTED METHOD OF CORRECTION: The facility could review the CDC guidelines for screening of TB. The facility could then create and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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	245267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2025**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/08/2025. At the time of this survey, St. Anthony Health and Rehab 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.	K 000		

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

Electronically Signed | 05/07/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. Anthony Health and Rehabilitation is a 2-story building without a basement that was built in 1967 and was determined to be of Type II(111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility shares a common wall with an assisted living facility that has a 2-hour fire rating.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 110 beds and had a census of 76 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/08/2025 at 11:35 AM, it was revealed by observation that a patient scale was in the corridor near resident room 200, restricting the clear width to 45". An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 211	1. Scale was moved to a different location 2. All staff educated regarding corridors not being blocked 3. Maintenance director or designee will audit 5 corridors weekly x4 weeks. QAPI will review audit results and recommend continued audit schedule.	5/19/25

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K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		5/19/25

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K 222	Continued From page 4 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors/ gates per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.5.3, 7.2.1.5.10, and 7.2.1.5.10.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2025 at 11:27 AM, it was revealed by observation that the latch on the gate exiting out of the courtyard the lounge room exits into did not have an obvious method of operation. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 222	1. Gate latch was replaced 2. Full house audit completed of egress gates. 3. The results of these audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing.	

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K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1 and 7.2.1.4.5.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2025 between 09:15 AM and 12:30 PM, it was revealed by observation that the door exiting out of the 2NW stairwell on the second floor was difficult to open. The Maintenance Director had to hit the door with his shoulder to open the door. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 225	1. Door was repaired and functioning properly 2. Full house audit was completed on fire doors. 3. Maintenance team was educated on checking all fire doors quarterly to ensure proper opening and closing. 4. Maintenance director and or designee will complete a full house audit of fire doors monthly. Results of audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing.	5/19/25
K 226 SS=E	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	K 226		5/19/25

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K 226	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, and 8.3.1.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2025 at 10:48 AM, it was revealed by observation that the firewall near the lobby stairwell had penetrations that were not sealed above the ceiling near the fire doors. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 226	1. Firewall was repaired 2. Full house audit completed for smoke barriers 3. Education was provided to maintenance regarding the importance of a sealed smoke barrier 4. The results of these audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install egress lighting per NFPA 101 (2012 edition), Life Safety Code, sections	K 281	1. Facility had egress lighting that illuminates exit door from lounge 2. This was verified with fire marshal on	4/24/25

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K 281	Continued From page 7 19.2.8, 19.7.3, 7.8, 7.8.1, 7.8.1.2, 7.8.1.2.2, 7.8.1.3, 7.8.1.4, 7.8.2, and 7.8.2.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2025 at 11:28 AM, it was revealed by observation that egress lighting was not installed outside of the exit door from the lounge room. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 281	4/24/25	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 04/08/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have been testing the emergency lighting in the facility.	K 291	1. Tests were completed and documented in facility maintenance program and will be tracked through there moving forward. Battery was replaced in the electrical room light and is functioning. 2. Full house audit completed on emergency lights 3. Maintenance department was educated on testing and recording emergency lighting testing 4. The results of these audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing.	5/19/25

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K 291	Continued From page 8 2. On 04/08/2025 at 11:52 AM, it was revealed by observation that the emergency light located in the physical therapy electrical room was non-operational. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 291		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		5/19/25

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K 321	Continued From page 9 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.1, 8.4.3.5, and 8.3.3.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2025 at 12:00 PM, it was revealed by observation that resident rooms 101. 103, and 106 were repurposed as storage rooms, and the doors do not have self-closing devices installed on them. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 321	1. Door closures were installed on rooms 100, 101, 103 and 106 2. No other rooms are being utilized for storage at this time 3. Maintenance department was educated on self-closing devices need to be on all storage rooms 4. The results of these audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		5/19/25

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	245267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 10 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain kitchen doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/08/2025 at 12:00 PM, it was revealed by observation that the door in the kitchen used to exit into the kitchen link was propped open with a wedge. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 324	1. Wedge was removed at the time of observation 2. No other doors were noted to be propped open 3. All staff were educated on propping doors open 4. Maintenance Director and/or designee will audit kitchen doors weekly for 4 weeks to ensure they are not being propped open. The results of audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351		5/19/25

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K 351	Continued From page 11 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to install the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.5, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.15.5.1, 8.15.5.2, 8.15.5.3, and 8.15.5.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2025 at 11:48 AM, it was revealed by observation that the elevator machine room in the boiler room did not have a sprinkler installed in it. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 351	1. Sprinkler head was installed 2. Whole house audit on elevator machine rooms for sprinkler heads was completed 3. The results of these audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing.	

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ST ANTHONY HEALTH & REHABILITATION	**3700 FOSS ROAD NORTHEAST** **ST ANTHONY, MN 55421**

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K 353	Continued From page 12	K 353		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/08/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available	K 353	1. 5 Year test was completed and new gauge was installed 2. 5 year testing will be completed within 5 years of the last inspection as required 3. Maintenance Director or designee is responsible for scheduling the 5 year sprinkler test. 4. Audits will be completed by Maintenance Director and/or designee as part of the preventative maintenance program to ensure that the 5 year sprinkler test is completed timely. Results of audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and	5/19/25

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ST ANTHONY HEALTH & REHABILITATION	**3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421**

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K 353	Continued From page 13 documentation that at the time of the survey, the facility could not provide a fire sprinkler 5-year inspection report. 2. On 04/08/2025 at 12:21 PM, it was revealed by observation that the gauges on the fire sprinkler riser were dated 11/09/15, making them older than 5 years. An interview with the Executive Director and the Maintenance Director verified these deficient findings at the time of discovery.	K 353	determine need for ongoing auditing.	
K 363 SS=D	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	K 363		5/19/25

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K 363	Continued From page 14 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/08/2025 at 11:19 AM, it was revealed by observation that the inactive leaf of the linen door near resident room 227 was not latched, causing the entire door to not positively latch. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 363	1. Door latch was fixed during this walk through. 2. No other inactive leafs in the facility at this time. 3. Education provided to staff regarding latching doors	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 372		5/19/25

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K 372	Continued From page 15 Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/08/2025 at 10:51 AM, it was revealed by observation that there were penetrations in the smoke barrier near the front entrance going to sub-acute caused by pipes and wires. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 372	1. Smoke barrier in the ceiling going to subacute was filled and repaired. 2. Whole house audit of smoke barriers was completed 3. 5 smoke barriers will be audited weekly x 4 weeks by Maintenance Director and/or designee results of audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761		5/19/25

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K 761	Continued From page 16 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/08/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide an updated annual fire door inspection report. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 761	1. An annual fire door inspection was completed 2. Annual fire door inspection will be completed within 12 months of the last inspection as required 3. Maintenance Director or designee is responsible for scheduling the annual fire door inspections. 4. Audits will be completed by Maintenance Director and/or designee as part of the preventative maintenance program to ensure that the annual fire door inspection is completed timely. Results of audits will be reviewed by Maintenance director and the quality assurance committee to ensure compliance and determine need for ongoing auditing.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99.	K 901		5/19/25

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K 901	Continued From page 17 Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/08/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide an NFPA 99 Risk Assessment. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 901	1. NFPA 99 Risk Assessment was completed 2. All components of NFPA 99 risk assessment will be completed annually as required. 3. Maintenance Director or designee is responsible for completing the NFPA 99 Risk assessment. Maintenance director has been educated on how to complete the NFPA 99 Risk assessment. 4. Compliance with this requirement will be monitored through routine inspections of fire documentation as conducted by Director of Maintenance and/or designee and the quality assurance committee to ensure compliance and determine need for ongoing auditing	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 911		5/19/25

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K 911	Continued From page 18 Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3 and 6.4.1.1.16.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, and 5.6.5.6.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2025 between 09:15 AM and 12:30 PM, it was revealed by observation that at the time of the survey, the facility could not locate an emergency stop button for the Kohler generator. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 911	1. An emergency stop button was ordered on 4/10/25, installation will occur at the soonest practicable date. 2. Other generator at facility has emergency stop button 3. Maintenance department was educated regarding ensuring if new generators get installed that emergency shut off also needs to be installed	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		5/19/25

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K 920	Continued From page 19 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/08/2025 at 12:16 PM, it was revealed by observation that there were multiple daisy-chained power strips in the main electrical room. An interview with the Executive Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 920	1. New outlets were installed and power strips were removed. 2. Other electrical rooms were audited and are in compliance 3. All staff education was completed on use of extension cords and power cords	