Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 15, 2024

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

RE: CCN: 245267
Cycle Start Date: October 7, 2024

Dear Administrator:

On November 15, 2024, the Minnesota Department of Health, 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
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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November 15, 2024

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

Re: Reinspection Results
Event ID: 70VD12

Dear Administrator:

On November 15, 2024, 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 October 7, 2024. 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
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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October 16, 2024

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

RE: CCN: 245267
Cycle Start Date: October 7, 2024

Dear Administrator:

On October 7, 2024, a survey was completed at your facility by the Minnesota Department of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 January 7, 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 April 7, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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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 10/07/2024

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
F 000	INITIAL COMMENTS On 10/3/24 to 10/7/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H52679241C MN00103210 H52679301C MN00103243 H52679301C MN00103234 H52679061C MN00105502 H52679240C MN00104883 H52679202C MN00102473 with a deficiency cited at F623, F625, F712, F883. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		11/6/24

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

Electronically Signed | 10/25/2024

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 623	Continued From page 1 language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F 623		

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F 623	Continued From page 2 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623		

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F 623	Continued From page 3 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Ombudsman for Long Term Care (LTC) of resident transfers to the hospital for 3 of 3 residents (R3, R4 and R5) reviewed for hospitalization. This had the potential to affect all residents transferred to hospital. Findings include: R3's significant change Minimum Data Set (MDS) dated 5/24/24, indicated diagnoses included cerebrovascular accident (stroke), diabetes, anemia, malnutrition, and epilepsy. R3's progress notes indicated R3 was hospitalized from 4/28/24 to 5/17/24. R3's record lacked evidence the Ombudsman for LTC was notified of R3's transfer to the hospital. R4's discharge Minimum Data Set (MDS) dated 4/12/24/24, indicated diagnoses which included peripheral vascular disease or peripheral arterial disease (impaired circulation to the peripheral (distant arteries) of the hands and feet), methicillin resistant staphylococcus aureus (MRSA) (an antibiotic resistant organism)	F 623	F623 Corrective Action for those residents found to have been affected by alleged deficient practice: Resident R3 discharged 5/28/24, Ombudsman LTC was notified on 10/4/24 Resident R4 discharged 4/12/24, Ombudsman LTC was notified on 10/4/24 Resident R5 discharged 5/14/24, Ombudsman LTC was notified on 10/4/24 Identify other residents having the potential to be affected: All residents being transferred to the hospital have the potential to be affected. Measures put into place, or systemic changes made, to ensure alleged deficient practice is being corrected and will not recur: Social Service Director and designee have received education on requirements for Ombudsman notification by 11/6/24. Policy reviewed. Audits have been developed regarding Ombudsman notification. Audits will be completed by Administrator or designee on all residents hospitalized 2x per month for 2 months	

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F 623	Continued From page 4 infection, pressure ulcer of unspecified joint, and local infection of the skin and subcutaneous tissue (the tissue which lies beneath the skin and above the muscle). R4's progress notes indicated R4 was hospitalized from 3/28/24 to 4/2/24. R4's record lacked evidence the Ombudsman for LTC was notified of R4's transfer to the hospital. Additionally, the document faxed to the Ombudsman for LTC titled Admit/Discharge To/From Report for March 2024, faxed by the social services director (SSD)-A lacked indication of the transfer to the hospital. R5's discharge assessment Minimum Data Set (MDS) dated 5/14/24, indicated diagnoses which included debility related to cardiorespiratory conditions, atrial fibrillation or other dysrhythmia, cirrhosis, diabetes mellitus, aphasia, malnutrition or at risk for malnutrition, anxiety disorder, respiratory failure, cataracts/glaucoma, or macular degeneration, and tricuspid valve insufficiency. R5's progress notes indicated R5 was hospitalized 4/21/24. The progress notes lacked indication the Ombudsman for LTC was notified of hospitalization. Additionally, the document faxed to the Ombudsman for LTC, titled Admit/Discharge To/From Report for April 2024, faxed by the social services director (SSD)-A lacked this information as well. R5's progress notes indicated R5 was discharged from the facility on 5/8/24. Although the record identified R5 was discharged from the facility on that date, the progress notes lacked indication the	F 623	then monthly x 2 months. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur: This and all deficiencies were brought to QAPI on 10/21/24. Results of the audits will be reviewed by the Administrator or designee and the Quality Assurance/Performance Improvement (QAPI) committee to ensure compliance and to determine need for further recommendations and/or ongoing auditing until substantial compliance is reached. The Administrator remains responsible for compliance with this requirements to notify the Ombudsman of LTC of residents transferred to hospital.	

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F 623	Continued From page 5 Ombudsman for LTC was notified of the discharge. Additionally, the document faxed to the Ombudsman for LTC, titled Admit/Discharge To/From Report for May 2024, faxed by the social services director (SSD)-A also lacked indication of facility discharge. During interview on 10/3/24 at 11:33 a.m., the social services director (SSD-A) indicated although she was aware of the need to the notify the Ombudsman for LTC of discharges from the facility, she was unaware of the need to notify the Ombudsman of any transfers to the hospital. The facility policy, Transfer and Discharged, last reviewed on 10/24/23, identified the Ombudsman would be notified of discharges from the facility. The policy lacked indication for notification of the Ombudsman of resident transfers to the hospital.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		11/6/24

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F 625	Continued From page 6 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a written notice of a bed hold upon transfer for hospitalization for 3 of 4 residents (R3, R4, and R5) reviewed for hospitalization. Findings include: R3's significant change Minimum Data Set (MDS) dated 5/24/24, indicated diagnoses included cerebrovascular accident (stroke), diabetes, anemia, malnutrition, and epilepsy. R3's progress note dated 4/28/24 at 6:27 p.m., indicated licensed practical nurse (LPN)-A found R3's gastrostomy tube (G-tube) had been pulled out, the on-call nurse practitioner (NP) was contacted and ordered R3 to be transported to emergency department (ED) for G-tube replacement. LPN-A notified family member (FM)-B of the situation via phone. R3's progress note dated 4/28/24 at 9:42 p.m., indicated R3 was admitted to Hennepin County Medical Center hospital (HCMC) due to a fever	F 625	F625 Corrective Action for those residents found to have been affected by alleged deficient practice: Resident R3 discharged 5/28/24 Resident R4 discharged 4/12/24 Resident R5 discharged 5/14/24 Identify other residents having the potential to be affected: All residents transferred to hospital have the potential to be affected. Measures put into place, or systemic changes made, to ensure alleged deficient practice is being corrected and will not recur: Licensed Nurses and Social Workers have received education on requirements for bed-hold notification by 11/6/24. Policy reviewed and revised. Audits have been developed regarding bed-hold notification. Audits will be completed by DON or designee on all residents hospitalized 1x per week for 4	

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F 625	Continued From page 7 and the need for further testing. R3's progress note dated 5/17/24 at 9:46 p.m., indicated R3 returned to the facility from HCMC on 5/17/24 at 5:28 p.m. Review of R3's records lacked evidence of a written notice of bed hold for R3's 4/28/24 to 5/17/24 hospitalization. R4's discharge Minimum Data Set (MDS) dated 4/12/24/24, indicated diagnoses which included peripheral vascular disease or peripheral arterial disease (impaired circulation to the peripheral (distant arteries) of the hands and feet), methicillin resistant staphylococcus aureus (MRSA) (an antibiotic resistant organism) infection , pressure ulcer of unspecified joint, and local infection of the skin and subcutaneous tissue (the tissue which lies beneath the skin and above the muscle). R4's progress notes indicated R4 was hospitalized from 3/28/24 to 4/2/24. R4's record lacked evidence a written notice of bed hold for R4's 3/28/24 to 4/2/24 hospitalizations. R5's discharge assessment Minimum Data Set (MDS) dated 5/14/24, indicated diagnoses which included debility related to cardiorespiratory conditions, atrial fibrillation or other dysrhythmia, cirrhosis, diabetes mellitus, aphasia, malnutrition or at risk for malnutrition, anxiety disorder, respiratory failure, cataracts/glaucoma, or macular degeneration, and tricuspid valve insufficiency.	F 625	weeks then 1x per month for 2 months. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur: This and all deficiencies were brought to QAPI on 10/21/24. Results of the audits will be reviewed by the DON or designee and the Quality Assurance/Performance Improvement (QAPI) committee to ensure compliance and to determine need for further recommendations changes and/or ongoing auditing until substantial compliance is reached. The Administrator and DON remains responsible for compliance with this requirements to ensure residents are provided bed-hold notice upon hospital discharge.	

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F 625	Continued From page 8 R5's progress notes indicated R5 was hospitalized 4/21/24. The progress notes lacked documentation of notification of the bed hold policy of the facility to either the resident, or the responsible party. On 10/3/24, at 4:25 p.m., the executive director (ED) stated she had reviewed the medical record and verified there were no documents to reflect a bedhold notifications were provided. On 10/3/24, at 4:36 p.m., the social services director (SSD)-A stated bedhold notifications were to be given when someone goes to the hospital. SSD-A went on to state that once the notification was provided, they should be uploaded to the electronic medical record. On 10/7/24, at 9:34 a.m. the director of nursing (DON) stated bedhold notifications were given to either the resident of the responsible party at the time of transfer/hospitalization. The bedhold notification was part of the medical record and was uploaded to the EMR. Further, the director of nursing (DON) and infection preventionist (IP) confirmed R3's record lacked evidence a written notice of bed hold had been provided for the 4/28/24 to 5/17/24 hospitalization. The facility policy, Transfer and Discharge, last reviewed 10/24/23, identified the notice of bed hold policy and readmission policy was to be provided before the facility transfers a resident to a hospital, or go on therapeutic leave. The policy identified if the transfer was an emergency, this notification, and subsequent documentation was to be provided within 24 hours of the transfer.	F 625		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP	F 712		11/6/24

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	245267	A. BUILDING _____ B. WING _____	C 10/07/2024

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F 712	Continued From page 9 CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure long term residents received routine physician visits (every 60 days) for 1 of 3 residents (R3) reviewed for routine physician care. Findings include: R3's significant change Minimum Data Set (MDS) dated 5/24/24, indicated diagnoses included cerebrovascular accident (stroke), diabetes, anemia, malnutrition, and epilepsy. R3's clinical record indicated R3's physician completed routine physician visits on 2/5/24 and	F 712	F712 Corrective Action for those residents found to have been affected by alleged deficient practice: Resident R3 discharged 5/28/24 Identify other residents having the potential to be affected: All residents have the potential to be affected. Measures put into place, or systemic changes made, to ensure alleged deficient practice is being corrected and will not recur:	

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F 712	Continued From page 10 5/22/24, greater than 60 days between visits. However, R3's clinical record lacked evidence a physician visit had been provided between 2/5/24 and 5/22/24. On 10/4/24 at 1:28 p.m., the administrator provided an email which contained "the entire chart from the provider" for R3. The provided chart indicated physician visits had been completed on 2/5/24 and 5/22/24, with no evidence of a physician visit within 60 days of 2/5/24. On 10/7/24 at 12:19 p.m., director of nursing (DON) and infection preventionist (IP) stated the medical records department only found physician visits for 2/5/24 and 5/22/24. The DON and IP confirmed R3's clinical record lacked evidence routine physician visits had been completed every 60 days between 2/5/24 and 5/22/24. The DON stated routine physician visits were important to ensure residents were taken care of properly. The facility's Physician Visitation and Monitoring and Notification policy, reviewed 2/5/24, indicated the attending physician, at a minimum, would visit residents every 30 days for the first 90 days after admission and every 60 days thereafter. A physician visit would be considered timely if performed no later than 10 days after the required visit date. At no time may the visitation period extend beyond 60 days.	F 712	Medical Records Director have received education on requirements for Physician Visits and frequency of visits by 11/6/24. Policy reviewed. Audits have been developed regarding Physician Visits and Frequency. Audits will be completed by DON or designee on 5 resident per week x 4 weeks, 5 residents per month for 2 months. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur: This and all deficiencies were brought to QAPI on 10/21/24. Results of the audits will be reviewed by the DON or designee and the Quality Assurance/Performance Improvement (QAPI) committee to ensure compliance and to determine need for further recommendations and/or ongoing auditing until substantial compliance is reached. The DON remains responsible for compliance with this requirements to ensure residents receive routine physician visits.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		11/6/24

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F 883	Continued From page 11 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 12 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 residents (R3, R9) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R3's significant change Minimum Data Set (MDS) dated 5/24/24, indicated R3's date of birth was	F 883	F883 Corrective Action for those residents found to have been affected by alleged deficient practice: Resident R3 discharged 5/28/24 Resident R9 received Pneumococcal on 10/24/24. Identify other residents having the potential to be affected: All residents have the potential to be affected. Measures put into place, or systemic changes made, to ensure alleged deficient practice is being corrected and will not recur: Licensed Nurses and Infection Preventionist received education on requirements for Pneumococcal Immunizations by 11/6/24. Policy reviewed. Audits have been developed regarding Pneumococcal Immunization. All residents in house have been offered the pneumococcal vaccine, and provided, if appropriate. Audits will be completed by IP or designee on all new admits for	

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F 883	Continued From page 13 2/10/1948 (76 years old), and diagnoses included cerebrovascular accident (stroke), diabetes, anemia, malnutrition, and epilepsy. R3's immunization report dated 10/3/24, indicated R3 received PPSV23 on 1/16/2014. The record lacked evidence of shared clinical decision-making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence R3 was offered or received PCV20. R9's quarterly MDS dated 9/5/24, indicated R9's date of birth was 6/28/1951 (73 years old), and diagnoses included acute and chronic respiratory failure and chronic kidney disease. R9's immunization report dated 10/3/24, indicated R9 received PCV13 on 8/15/2016 and PPSV23 on 2/12/2018. The record lacked evidence of shared clinical decision-making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence R9 was offered or received PCV20. On 10/7/24 at 12:19 p.m., director of nursing (DON) and infection preventionist (IP) confirmed R3's record lacked evidence R3 was offered, declined, and/or received PCV20. Additionally, DON and IP confirmed R9's record lacked evidence R9 was offered, declined, and/or received PCV20. The IP stated immunizations should have been reviewed during care conferences to determine if a resident was eligible and offered PCV20, and PCV20 was important to fight against pneumonia and/or lessen the effects of infection. The facility's Pneumococcal Vaccine (Series)	F 883	consent/declination and administration (if appropriate) for pneumococcal vaccination 1x per week 4 weeks. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur: This and all deficiencies were brought to QAPI on 10/21/24. Results of the audits will be reviewed by the IP or designee and the Quality Assurance/Performance Improvement (QAPI) committee to ensure compliance and to determine need for further recommendations and/or ongoing auditing until substantial compliance is reached. The IP remains responsible for compliance with this requirements to ensure residents were offered and/or provided the pneumococcal vaccine series.	

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F 883	Continued From page 14 policy, reviewed 10/16/2023, indicated the facility would provide immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations.	F 883		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 16, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 70VD11

Dear Administrator:

The above facility was surveyed on October 3, 2024, through October 7, 2024, 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 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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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 10/3/24 to 10/7/24, a complaint 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 licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52679061C MN00105502 H52679240C MN00104883 H52679202C MN00102473 H52679241C MN00103210 H52679301C MN00103243 H52679301C MN00103234 with a licensing order issued at 1290 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 surveyor ' s 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 14-01, available at <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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure long term residents received routine physician visits (every 60 days) for 1 of 3 residents (R3) reviewed for routine physician care. Findings include: R3's significant change Minimum Data Set (MDS) dated 5/24/24, indicated diagnoses included cerebrovascular accident (stroke), diabetes,	21290	Corrected	11/6/24

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21290	Continued From page 3 anemia, malnutrition, and epilepsy. R3's clinical record indicated R3's physician completed routine physician visits on 2/5/24 and 5/22/24, greater than 60 days between visits. However, R3's clinical record lacked evidence a physician visit had been provided between 2/5/24 and 5/22/24. On 10/4/24 at 1:28 p.m., the administrator provided an email which contained "the entire chart from the provider" for R3. The provided chart indicated physician visits had been completed on 2/5/24 and 5/22/24, with no evidence of a physician visit within 60 days of 2/5/24. On 10/7/24 at 12:19 p.m., director of nursing (DON) and infection preventionist (IP) stated the medical records department only found physician visits for 2/5/24 and 5/22/24. The DON and IP confirmed R3's clinical record lacked evidence routine physician visits had been completed every 60 days between 2/5/24 and 5/22/24. The DON stated routine physician visits were important to ensure residents were taken care of properly. The facility's Physician Visitation and Monitoring and Notification policy, reviewed 2/5/24, indicated the attending physician, at a minimum, would visit residents every 30 days for the first 90 days after admission and every 60 days thereafter. A physician visit would be considered timely if performed no later than 10 days after the required visit date. At no time may the visitation period extend beyond 60 days. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures of	21290		

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21290	Continued From page 4 frequency of visits by the provider. The administrator or designee could educate all appropriate staff on these policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21290		