

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER St Anthony Park Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 Commonwealth Avenue Saint Paul, MN 55108	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and document review the facility failed to ensure 1 of 8 staff nursing assistant (NA)-M had completed the required Alzheimer's and dementia care training program. This had the potential to affect all residents in the facility who had an Alzheimer's or dementia diagnosis. Findings include: On 8/13/26 at 8:48 a.m., a request was made to the administrator and the director of nursing (DON) for Alzheimer's and/or dementia care training for eight employees. During an interview on 8/13/26 at 12:05 p.m., the administrator stated they were unable to find Alzheimer's or dementia care training for NA-M who had a start date of 9/9/25. It is the expectation all staff were to receive Alzheimer's and/or dementia care training before working with residents and should also have documentation of the training being completed. A policy related to Alzheimer's and dementia care training was requested, but none was received.		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to honor a request for different room lighting for 1 of 1 resident (R5), reviewed for self-determination. Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated a diagnosis of moderate unspecified dementia. Behaviors related to disorganized thinking, altered level of consciousness, or difficulty focusing attention were not present. R5's care plan dated 6/23/26 included a primary diagnosis of Sjogren syndrome (an autoimmune disorder where the immune system attacks the body's moisture producing glands) with keratoconjunctivitis (inflammation of the cornea), which can cause pain, impaired eyesight, and light sensitivity. During observation and interview on 8/11/26 at 12:49 p.m., R5 was noted to be cognitively alert and able to answer questions appropriately. R5 stated she really hated the lights in her room. She described the lighting as too white, bright, and harsh. The two lights which bothered her the most were the circular overhead light located between the two resident spaces in the room and the rectangular wall light above her bed. Nursing assistant (NA)-A was in the room during the interview. R5 mentioned the bright lights to NA-A and he responded by shutting the lights off. The resident stated, That is what they always do whenever I complain about the lights. They just shut them off. The resident stated she would prefer different bulbs, with a softer, more yellow light. During an interview on 8/12/26 at 8:49 a.m., registered nurse (RN)-B stated if a resident complained about the lighting in their room, she would complete a work order form and forward it to maintenance. She said R5 had occasionally complained the light in her room was too bright and RN-B said she usually responded by turning off the lights. She had not completed a work order for R5. RN-B mentioned she once had a request from another resident to remove the light bulb completely from a fixture in the room but was told by maintenance that they could not do that. During an interview on 8/12/26 at 9:04 a.m., the Director of Maintenance (DOM) stated the normal process for replacing lighting in a resident room was for nursing staff to send him a maintenance request. He said he had not received any requests recently for different lighting or light bulbs in any of the rooms, but he could change out the bulbs if lights were too bright. The DOM stated he had a variety of bulbs available, including a good stock of the older halogen and incandescent light bulbs. During an interview on 8/12/26 at 1:59 p.m., RN-A stated if a resident mentioned the lights were too bright in their room, staff were expected to offer to turn them off. If a resident expressed concerns regarding the type of light in their room, RN-A stated staff were expected to submit a work order request to maintenance. She was not aware of R5's request and had not submitted a work order. During an interview on 8/13/26 at 11:23 a.m., the Director of Nursing (DON) stated nursing staff were expected to contact maintenance if a resident complained about the lighting or requested a different type of lighting in their room. A policy regarding resident choices was requested but not received.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a PRN (as-needed) antipsychotic medication was limited to 14 days and that the continued use of the PRN antipsychotic medication was evaluated by the attending physician or prescribing practitioner for 1 of 1 residents (R12) reviewed for unnecessary medications. Findings include: R12's admission Minimum Data Set (MDS) dated [DATE], identified R12 had a severe cognitive impairment and diagnoses that included Alzheimer's disease and dementia. R12 received hospice services and used antipsychotic, antianxiety and opioid medications. R12's care plan revised 7/16/26, The resident has a behavioral problem of refusing cares and wandering related to Alzheimer's disease, peripheral vascular disease and dementia with agitation. Staff were directed to: Administer medications as ordered. Monitor/document for side effects. Explain all cares to the resident before starting and allow time to adjust to changes. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. R12's Order Summary Report dated 8/11/26, identified the following orders: 7/4/26 - 7/8/26 haloperidol 2 milligram (mg)/milliliter (ml) solution Give 0.5 ml by mouth every 4 hours as needed (PRN) for agitation and delirium. 7/8/26 - 7/10/26 haloperidol 2mg/ml solution Give 0.5 ml by mouth every 4 hours as needed for agitation and delirium for 10 Days. 7/10/26 - open ended haloperidol 2mg/ml solution Give 0.5 ml by mouth every 4 hours as needed for agitation and delirium. The 7/10/26 order was written as open-ended, rather than being limited to 14 days as required for a PRN antipsychotic medication. R12's Electronic Medication Administration Record (EMAR) dated 7/20/26, identified R12 received a PRN dose of haloperidol 6 times. R12's EMAR dated 8/11/26, identified R12 had received a PRN dose of haloperidol 1 time. R12's physician progress note dated 7/7/26, indicated R12 had Alzheimer's disease with late onset: advanced dementia with behavioral disturbance. R12 exhibited advanced cognitive impairment and was disoriented, unable to make needs known. R12 had a history of agitation, nonsensical speech and required assistance with all activities of daily living (ADLs). R12 had no reported hallucinations and had intermittent agitation. Continue haloperidol 1 mg every 4 hours PRN agitation. Maintain structured environment and safety precautions. R12's physician progress note dated 7/28/26 identified R12 had advanced dementia and was unable to reliably communicate needs. R12 had a history of agitation which was currently controlled, no reported hallucinations, and required full assistance with ADLs. The physician directed continuation of haloperidol 1 mg (0.5 mL) every 4 hours PRN for agitation and continued non-pharmacological behavioral interventions. However, the note did not identify an evaluation addressing the appropriateness and continued need for the PRN antipsychotic medication or provide an adequate rationale for renewal of the PRN order. R12's nursing progress note dated 7/10/26 at 6:20 a.m., identified a monthly regimen review (MRR) - see report for recommendation. R12's MRR dated 7/10/26 was requested but not received. R12's nursing progress note dated 7/19/26 at 2:07 p.m., identified R12 was an [AGE] years old male and was alert and oriented with confusion. R12 needed two assist for transferring and ADLs. R12 became restless that morning, and PRN haloperidol 0.5 ml was administered at 9:17 a.m. and was effective. However, the note failed to identify what non-pharmacological interventions were attempted prior to administration of haloperidol. During an interview on 8/12/26 at 1:58 p.m., licensed practical nurse (LPN)-C stated R12 did have a lot of agitation when he was first admitted to the facility R12 would stand up, try to walk and fall. It was really bad there for a while. R12 had settled down and became used to living at (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. Staff sat with R12, tried to calm him down and then if nothing worked, R12 had a PRN medication as well. During an interview on 8/13/26 at 9:01 a.m., the director of nursing (DON) stated R12 should have had a 14-day face-to-face evaluation to ensure the ongoing need for PRN antipsychotropic medication to prevent unnecessary medications or unnecessary sedation. During a telephone interview on 8/13/26 at 8:01 a.m., the pharmacist stated she had reviewed R12's medications on 7/10/26 and again on 8/12/26. On 7/10/26, the pharmacist stated she informed the facility R12's haloperidol did not have an appropriate rationale for use and that PRN antipsychotropic medications required a face-to-face medical provider evaluation every 14 days to ensure the PRN order needed to be continued. On 8/12/26, R12's haloperidol order was discontinued, and the pharmacist had no further recommendations. The pharmacist stated agitation and delusions were an inappropriate indication for use and PRN medications needed to be evaluated every 14 days to prevent misuse such as staff convenience. The facility policy Use of Psychotropic Medication undated, identified psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted: PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure written transfer notices were provided as soon as practicable for 1 of 1 resident (R79) reviewed for hospitalization. Findings include: R79's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R79 had severe cognitive impairment. R79's progress note dated 2/7/26 at 12:12 a.m., indicated R79 slept most of the time, had a decreased level of consciousness, and was nonverbal. R79's daughter was designated as her legal representative. R79's progress note dated 7/4/26 at 11:28 p.m., indicated R79 was transferred to the emergency department by ambulance for labored respirations and a change in level of consciousness. The note indicated verbal consent was obtained via phone from R79's daughter for a bed hold. A review of R79's medical record lacked evidence that written transfer and bed-hold notices were sent with R79 to the hospital and/or provided to the resident representative. During an interview on 8/12/26 at 8:06 a.m., licensed practical nurse (LPN)-A stated she sent documents such as a medication list, the most recent vital signs, and Physician's Orders for Life-Saving Treatment (POLST) with any resident who transferred to the hospital. LPN-A stated she was not familiar with a written transfer notice. She said standard practice was to contact family to see if they wanted to place a bed hold. If they did, she filled out a paper bed-hold form. This form was kept at the facility and was not sent with the patient or given to the resident representative. During an interview on 8/12/26 at 9:06 a.m., LPN-B stated the paperwork sent with residents transferring to the hospital included the resident's face sheet, diagnoses, POLST, medications, immunizations, and most recent progress note. Bed holds were documented on a paper form which was then scanned to the resident's medical record. LPN-B stated she completed a progress note when a resident transferred to the hospital which typically said, 911 called. Paperwork sent. Bed hold placed. She stated written transfer notices or bed-hold forms were not sent with the resident or provided to the resident's representative. She said a copy of the bed-hold notice was faxed to the ombudsman and the Minnesota Department of Human Services (DHS) by the medical records department. During a subsequent interview on 8/12/26 at 10:15 a.m., LPN-A confirmed she was unable to find either a written transfer notice or a written bed hold notice associated with R79's transfer to the hospital on 7/4/26 in R79's medical record. During an interview on 8/13/26 at 1:47 p.m., the Director of Nursing (DON) stated when a patient transferred to the hospital, the resident or family was asked whether they would like to hold the bed. Nursing staff filled out a paper bed-hold form and then gave this to medical records to be scanned into the resident's chart. The DON stated she did not know if a written transfer notice and/or a written bed hold notice was required to be sent with the resident or provided to the resident's representative. An undated policy titled Transfer and Discharge (including AMA) provided by the facility on 8/13/26, indicated that in the event of a transfer or discharge, the facility's transfer/discharge notice will be provided to the resident and/or the resident representative in a language and manner in which they can understand. The notice was to include the details of the transfer and information on how to appeal the transfer. The Transfer and Discharge policy also specified the information that was to be given to the receiving provider in the event of a transfer. An undated policy titled Bed Hold Notice provided by the facility on 8/13/26, indicated that in the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The written bed-hold notice was to specify the duration of the State bed-hold policy, the reserve bed payment policy, the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policies regarding bed-hold periods, and the conditions upon which the resident would return to the facility.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 1 residents (R77) reviewed for MDS accuracy. Findings include: R77's quarterly Minimum Data Set (MDS) dated [DATE], identified R77 had a severe cognitive impairment and diagnoses that included Type I Diabetes and Alzheimer's disease. The MDS also identified R77 had 2 deep tissue injuries (DTI) and used a pressure reducing device for her bed and chair. However, R77's electronic medical record (EMR) identified R77's DTI were healed 6/9/26. R77's Weekly Wound Documentation dated 6/9/26, identified R77's DTI on each heel had healed. R77's physician order dated 6/9/26 to 7/7/26, identified Wound Care - Left Heel Unstageable DTI Using Clean / Aseptic Technique 1. Apply Skin Prep to area and let dry daily and as needed. During an interview on 8/12/26 at 2:02 p.m., registered nurse (RN)-E stated R77 did have a deep tissue area to each of her heels, but the areas had healed and R77's weekly wound notes reflected that. During an interview on 8/12/26 at 2:07 p.m., RN-G stated she was responsible for completing R77's MDS. RN-F reviewed all assessments and R77's medical record to gather the required information. RN-F stated she was unsure why she had entered R77 had two DTI. RN-F stated she would do further review, but to find out if it was entered in error. RN-F stated MDS accuracy was very important because it affected billing and proper resident care because it determined what would be care planned for R77. At 2:45 p.m., RN-F stated she had entered two DTI for R77 because R77 had been receiving wound care until 7/7/26. At 2:57 p.m., RN-E stated R77's wounds were healed on 6/9/26 and the following wound care until 7/7/26 was a preventative measure. RN-F stated the DTI should not have been identified on R77's MDS and the DTI was entered in error. During an interview on 8/13/26 at 9:12 a.m., the director of nursing (DON) stated MDS accuracy affected everything: level of care, the resident care plan, just everything and should reflect the resident's current needs. A MDS accuracy facility policy was requested but not received.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care, shaving) was provided for 2 of 2 residents (R58, R5) reviewed for activities of daily living (ADLs) and were dependent on staff for their care. Findings include: R58 R58's quarterly Minimum Data Set (MDS) dated [DATE], indicated R58 was cognitively impaired, had no behaviors, did not refuse personal cares, needed maximal assistance with personal hygiene, and was dependent on toileting hygiene and bathing. R58's Clinical Diagnosis report dated 8/12/26, indicated diagnoses of unspecified dementia with mood disturbance, macular degeneration, major depressive disorder, hypertension, and vascular dementia. R58's Activities of Daily Living (ADLs) Care Plan dated 8/12/26, indicated R58 had a self-care deficit related to moderate cognitive impairment and diagnosis of dementia. R58's care plan indicated she was dependent on staff with bathing and personal hygiene. During observation on 8/10/26 at 12:32 p.m., R58 was awake in bed, but did not answer any questions. R58's nails were uneven in length and shape. The nails length ranged between 1 centimeter (cm) to 1.5 cm in length. During interview on 8/11/26 at 11:46 a.m., nursing assistant (NA)-C stated the NAs checked the residents' fingernails and toenails on shower days and cut them as needed. NA-C added the nurses cut the nails of residents with diabetes. During observation and interview on 8/12/26 at 8:21 a.m., R58 was in the dining room sitting up in her wheelchair. R58's clothes were clean, but her nails were still long, uneven and had black matter underneath. During interview on 8/12/26 at 8:36 a.m., licensed practical nurse (LPN)-B verified R58's fingernails were long, uneven, and had black matter underneath. LPN-B stated she would try to cut them, but most likely, R58 would refuse. During interview on 8/13/26 at 9:51 a.m., director of nursing (DON) stated the residents' nails needed to be cut on their shower day. DON stated NAs were supposed to attempt cutting residents nails, and if they failed, NAs needed to report this failure to the nurses. The nurses also needed to reapproach to try and cut the residents' nails. DON stated the facility had ordered different nail care supplies and would try to file F58's fingernails. DON stated long nails get dirty and they were an infection control issue. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested a facility's policy about Nail Care but none was provided. R5 R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated a diagnosis of moderate unspecified dementia. Behaviors related to disorganized thinking, altered level of consciousness, or difficulty focusing attention were listed as not present. R5's MDS indicated she was dependent on staff for personal hygiene and toileting and required maximal assistance with showering/bathing. A review of R5's care plan dated 6/23/26, did not specify the need to assess and shave facial hair. During an interview on 8/10/26 at 3:27 p.m., R5 was noted to be cognitively alert and able to answer questions appropriately. She stated that the whiskers on her chin really bothered her and she wished she could do something about them. Light grey hairs approximately 1/4 inch in length were observed to extend across the bottom of R5's chin. R5 mentioned this facial hair on three different occasions throughout the interview, and she vigorously rubbed the whiskers back and forth with her hand several times. R5 stated she has mentioned the whiskers to staff multiple times but had never received any response or any offers to shave them. During observation on 8/11/26 at 12:47 p.m., facial whiskers were still visible on R5's chin. During an interview on 8/11/26 at 3:35 p.m., nursing assistant (NA)-A stated shaving depended on resident preferences. Most residents preferred to be shaved every day. Orders were not typically placed for shaving as it was considered a thing we just do. NA-A said many residents had their own razors but otherwise, the facility provided them. He stated female residents were not typically asked about shaving facial hair. He said he only knew of one woman who shaved her facial hair regularly and she did this herself. NA-A said he had not received a request from R5 to shave her facial hair, and he has never offered to do it for her. During an interview on 8/11/26 at 3:48 p.m., NA-B stated that her residents varied in terms of shaving requests. She said that she shaved her residents every day unless they told her not to. NA-B stated if a female resident requested to be shaved, she would just do it. She has never asked a female resident if they wanted their facial hair to be shaved. During observation on 8/12/26 at 11:35 a.m., facial whiskers were still evident on R5's chin. During an interview on 8/12/26 at 1:55 p.m., registered nurse (RN)-A stated shaving was not typically included in the care plan. She said NAs were expected to shave or offer shaving to every resident each morning. Shaving was considered a standard of care, like brushing teeth, washing faces, applying deodorant, etc. NAs were also expected to offer shaving to female residents, especially if they noticed unexpected facial hair. During an interview on 8/13/26 at 11:20 a.m., the Director of Nursing (DON) stated daily shaving was a standard of care for both males and females. She stated that NAs were expected to offer this service to every resident and if a resident refused, the NA should inform the RN so the refusal could (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a sleeve protector was provided in accordance with the comprehensive care plan for 1 of 1 residents (R12) reviewed for pressure ulcers. Findings include: R12's admission Minimum Data Set (MDS) dated [DATE], identified R12 had a severe cognitive impairment and diagnoses that included Alzheimer's disease, dementia and peripheral vascular disease. R12 required partial/moderate assistance with upper body dressing and footwear. R12 was at risk for pressure ulcer/injury but had no pressure ulcers. R12's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 7/8/26, identified R12 was at risk for pressure ulcers and required a pressure relieving device for his bed and chair. R12's care plan revised 7/28/26, identified R12 had a skin tear/potential for skin tear of the left anterior shin and left posterior calf related to falling and hitting self on wheelchair. Staff were directed R12 needed protective sleeves to his left elbow at all times. During an observation on 8/10/26 at 11:50 a.m., R12 was seated in his tilt-in-space wheelchair in the dining room eating his meal. R12 was not wearing a protective sleeve to his left elbow. During an observation on 8/11/26 at 11:00 a.m., R12 was seated in his tilt-in-space wheelchair in the dining room. R12 was reclined back and was audibly snoring with his mouth hanging open. R12 was not wearing a protective sleeve to his left elbow. During an observation on 8/11/26 at 1:30 p.m., R12 was sitting in his tilt-in-space wheelchair at the table in the dining room. R12 was awake and tapping on the table to the beat of the music playing on the radio. R12 was not wearing a protective sleeve to his left elbow. During an observation on 8/12/26 at 7:10 a.m., R12 was sitting in his tilt-in-space wheelchair in the dining room. R12 was not wearing a protective sleeve to his left elbow. During an observation on 8/13/26 at 8:37 a.m., R12 was seated in his tilt-in-space wheelchair in the dining room. R12 was not wearing a protective sleeve to his left elbow. During an interview on 8/13/26 at 8:42 a.m., nursing assistant (NA)-D stated she had been the nursing assistant assigned to R12 all week. NA-D did not put the protective sleeve on R12 because if she did R12 would take it off and chew on it. During an interview on 8/13/26 at 8:51 a.m., registered nurse (RN)-D stated he was unaware R12 was not wearing the protective sleeve but R12 should wear a protective sleeve if it was a care planned intervention for R12. During an interview on 8/13/26 at 8:57 a.m., the director of nursing (DON) stated R12's sleeve protector should be assessed and removed from his care plan if inappropriate. However, staff were expected to follow the resident care plan to ensure the resident received the care needed for the resident. The facility policy Pressure Injury Prevention Guidelines revised 6/1/26, identified Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. In the absence of prevention orders, the licensed nurse will utilize nursing judgment in accordance with pressure injury prevention guidelines to provide care and will notify physician to obtain orders. The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. Considerations for needed modifications include: Development of a new pressure injury. Lack of progression towards healing or changes in wound characteristics. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER St Anthony Park Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 Commonwealth Avenue Saint Paul, MN 55108	
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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide the ordered services for the behavioral health needs for 1 of 1 resident (R22) reviewed for mood and behavior. Findings Include: R22's quarterly Minimum Data Set (MDS) dated [DATE], indicated R22 was cognitively intact, and had no hallucinations or delusions. The MDS indicated R22 was depressed, had trouble falling asleep, had poor appetite, and had diagnoses of heart failure, Parkinson's disease, anxiety and depression disorder. R22's Medical orders dated 7/13/26, indicated an order for escitalopram oxalate 10 milligrams daily for depression. This order was dated 7/30/24. R22's care plan dated 7/13/26, indicated resident had potential for alteration in mood related to depression, and anxiety. The interventions directed staff to arrange for a psychology and follow-up consult as indicated. It also directed staff to discuss with the resident any concerns, fears, and issues regarding health, or other subjects routinely. Furthermore, the care plan indicated R22 needed time to talk and encouragement to express her feelings. R22's medical record indicated she had a care conference on 7/6/26. The Social Services note indicated R22 was cognitively intact, had mild signs and symptoms for depression, and had no behaviors. The note also indicated R22 saw psychology on a regular basis. R22's electronic medical record (EMR) identified an order for psychology to evaluate and treat. The order was dated 4/13/26. The EMR lacked documentation of psychology visits in the last 12 months, which contradicts 7/6/26 social services documentation that R22 saw psychology on a regular basis. During observation and interview on 8/10/26 at 1:17 p.m., R22 stated she got sad very often, especially when her son visited her. R22 said, I just start crying and I can't stop crying. I am sad, am thinking about dying. I am old, I know I am going to die. R22 said she would like to talk to somebody. She said she used to talk to somebody, and it helped her. R22 said she would like to talk to a counselor. During interview on 8/12/26 at 2:26 p.m., DON stated social services oversaw the processing of psychology orders. During interview on 8/13/26 at 8:56 a.m., the social services director (SSD) stated R22 used to receive psychology services but was discharged in December 2024. SSD stated she received R22's order dated 4/13/26, but did not send the referral to psychology. During a follow-up interview on 8/13/26 at 9:40 a.m., SSD stated she needed to obtain a new consent and send the referral to psychology. SSD added, when she started in March, she had not received very much training, and she was unaware the facility had in-house visits from psychology. The SSD stated if she knew about this service, she would have made a list of all the residents who did or were supposed to see psychology to ensure this was occurring. During interview on 8/13/26 at 9:44 a.m., DON stated she expected the social workers would fax the referral orders to psychology as soon as possible and have residents seen as ordered. Requested the facility's policy about referral to psychosocial services but none was received.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate monitoring was in place for 1 of 1 resident (R9) on a high-risk medication (i.e., a diuretic), reviewed for unnecessary medications. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], included diagnoses of coronary artery disease with angina pectoris (chest pain), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). R9's diagnoses also included moderate cognitive deficit and unspecified dementia with impaired decision making and poor short-term memory. A review of R9's order set located in the facility's electronic medical record (EMR) dated 6/5/26, listed the following provider orders: 9/8/21: Knee high compression bandages placed in the morning and removed at bedtime 3/4/25: Orthostatic blood pressure assessment completed weekly 7/7/25: 2-gram sodium diet 8/7/25: 40 milligrams (mg) of furosemide (Lasix), a diuretic, to be given to be given by mouth once per day 4/7/26: Shortness of breath to be assessed three times per day R9's medical record lacked evidence of orders for weights or edema monitoring. R9's care plan dated 7/12/26, indicated R9 was on diuretic therapy related to excess fluid. Interventions listed included: administer diuretic medications as ordered by physician, monitor for side effects and effectiveness every shift, and report pertinent labs results to the provider. R9's care plan also indicated staff were to monitor/document/report any changes in edema and weight. However, the record lacked evidence of specific parameters for provider notification of changes in edema and/or weight. A nutrition/dietary progress note dated 1/8/26 at 5:08 p.m., indicated R9's furosemide was increased on 8/27/25, and R9 had the potential for weight fluctuations related to edema and the diuretic. A review of R9's weight summary dated 8/12/26, indicated weights were done monthly with the following results: 6/6/26: 227 pounds 7/13/26: 235 pounds 8/6/26: 227 pounds R9's medical record lacked evidence of provider notification of the eight-pound weight fluctuations. During an interview on 8/13/26 at 1:15 p.m., registered nurse (RN)-C stated she monitored for edema, shortness of breath, blood pressure changes, and congestion in any resident taking a diuretic. She expected weights to be ordered and completed weekly. During an interview on 8/13/26 at 1:37 p.m., RN-D stated he cared for R9 frequently. He stated since R9 was on furosemide, he monitored for shortness of breath and swelling. If he noticed an increase in edema, he obtained a weight and notified the provider. RN-D stated R9 wore compression bandages on his legs for edema, and these were put on by nursing staff in the morning and removed at night. RN-D stated he believed R9 was on weekly weights. However, after reviewing R9's record, he stated R9 did not have an order for weekly weights, and he confirmed there were no orders for edema monitoring and no specific parameters for provider notification. During an interview on 8/13/26 at 1:52 p.m., Nurse Practitioner (NP)-A. stated since R9 was on furosemide, nursing staff should check for worsening edema regularly. She was not sure if the facility had edema monitoring in place, but she expected staff to take weights at least weekly and update her with a weight gain of greater than five pounds in a week. During an interview on 8/13/26 at 2:23 PM, the Director of Nursing (DON) stated for residents on furosemide, nursing staff were expected to regularly monitor for edema and obtain weights weekly. The DON confirmed weights were being done monthly for R9 and that there were no orders in place for edema monitoring. The DON also confirmed there were no parameters listed for provider notification when changes in weight and/or edema were noted. The DON stated that two weeks ago, she changed weights from monthly to weekly for all residents based on their diagnoses and/or medications, including diuretics. She stated R9 must have been missed. A review of the policy titled High Risk Medications dated 4/12/26, stated the resident's plan (continued on next page)		

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of care shall alert staff to monitor for adverse consequences of any high-risk medications and include interventions to minimize the risk of adverse consequences.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 1 resident (R10) reviewed for catheter and 1 of 1 resident (R2) reviewed for pressure ulcers. Findings include: R10's quarterly Minimum Data Set (MDS) dated [DATE], identified R10 had a moderate cognitive impairment and diagnoses that included Type 2 Diabetes and obstructive reflux uropathy (a blockage that stops urine from flowing normally through the urinary tract). R10 required an indwelling catheter and was dependent on staff for assistance with toileting. R10's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 1/4/26, identified R10 had an indwelling catheter. Interventions included were to ensure tubing was not kinked, bag was covered, monitoring for urinary tract infection (UTI) symptoms, etc. The CAA directed to review R10's care plan. R10's care plan revised 6/14/26, identified R10 required Enhanced Barrier Precautions (EBP) due to have an indwelling catheter. Staff were directed: Alcohol based hand rub in room Educate resident/ family on EBP and answer any questions or concerns EBP per CDC guidelines EBP signs on doors Garbage in room by exit for personal protective equipment (PPE) removal Gown/gloves prior to high care contact (face mask plus goggles must be worn in activity at risk for high splash or spray) Incorporate periodic monitoring and assessment of adherence to recommended infection prevention practices Use PPE during high contact dressing, bathing/showing, transferring, hygiene, changing linen, changing briefs, toileting device care or wound care. During an observation on 8/11/26 at 3:26 p.m., there was an isolation door caddy with disposable gowns and gloves hanging on R10 with a sign that stated R10 required EBP. Registered nurse (RN)-D and nursing assistant (NA)-E assisted R10 to his room and encouraged R10 to lie down for a while. RN-D put on a disposable gown and gloves but NA-E did not. NA-E cleared R10's personal items from the top of R10's bed and then assisted R10 to stand up from his wheelchair. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:28 p.m., NA-E pulled R10's wheelchair away from R10 while R10 stood holding his front-wheeled walker. NA-E assisted R10 to turn and sit on his bed, then removed R10's shoes. At 3:29 p.m., NA-E assisted R10 to stand again and pulled down R10's pants. R10 sat down on the bed again so NA-E could remove his pants paying attention to wear his indwelling catheter bag was, NA-E stated R10 was ok'ed to stand up on his own as well before asking R10 to stand back up. NA-E removed R10's soiled brief and cleaned feces from R10's skin using a disposable wipe. At 3:34 p.m., NA-E removed her gloves, washed her hands in the bathroom sink and left the room. RN-D assisted R10 to lie down on his bed. During an interview on 8/12/26 at 2:22 p.m., NA-E stated 5 weeks ago there was a meeting and staff were told it was facility policy to wear a gown and gloves with any resident that had a catheter. NA-E again stated it was facility policy and wasn't a state reg. NA-E then stated that she was going to be honest and staff didn't wear the gown or gloves when they were busy. During an interview with RN-E and RN-G on 8/12/26 at 2:57 p.m., RN-E and RN-G stated staff were expected to follow EBP per CDC guidelines. During an interview on 8/13/26 at 9:07 a.m., the director of nursing (DON) stated EBP was an important intervention to stop the spread of infection for residents without indwelling catheters and staff were expected to follow EBP according to CDC guidelines. R2 R2's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R2 was cognitively intact. Diagnoses included multiple sclerosis, obesity, diabetes mellitus, and a right below-the-knee amputation (BKA). R2's MDS also indicated diagnoses of neurogenic bladder and obstructive uropathy for which R2 had an indwelling suprapubic urinary catheter. R2's MDS specified he was always incontinent of bowel. R2 was dependent on staff for toileting, showering, and dressing, and required moderate assistance with personal hygiene. He used a wheelchair for mobility and was dependent on staff for repositioning in bed and all transfers. R2's wound/skin care progress note dated 8/4/26, indicated R2 had a stage 4 pressure ulcer on his left buttock with a wound vacuum in place. He also had a stage 3 sacral pressure ulcer and a chronic diabetic left foot ulcer. R2's care plan revised on 5/12/26, identified Enhanced Barrier Precautions (EBP) were initiated on 1/18/26, related to his urinary catheter and pressure ulcers. Staff were directed to: Alcohol-based hand rub in room Educate resident/ family on EHBP and answer any questions or concerns EBP per CDC guidelines (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP signs on doors Garbage in room by exit for PPE removal Gown/gloves prior to high care contact including dressing, bathing/showering, transferring, hygiene, changing linen, changing briefs or toileting, device care, or wound care During an observation on 8/12/26 at 7:16 a.m., there was an isolation caddy with disposable gowns and gloves hanging on R2's door with a sign that indicated R2 required EBP. The hand sanitizer dispenser outside R2's door was empty. A hand sanitizer dispenser inside R2's room near the door was full. R2 was observed eating breakfast in bed. At 7:33 p.m., NA-G arrived at R2's room with a Hoyer lift accompanied by NA-H. Both NA-G and NA-H put on gloves and a disposable gown. NA-G was observed to be wearing her gown open to the front, like a jacket or housecoat. NA-G and NA-H entered R2's room and closed the door. At 7:40 a.m., NA-H opened the door while wearing her gown and gloves, removed her gown and gloves in R2's room, and placed them into the wastebasket in R2's room. She exited the room without performing hand hygiene and returned the Hoyer lift to the storage room across the hall. NA-H stated they had changed R2's brief, emptied his catheter bag, dressed him, and transferred him to the wheelchair with the Hoyer lift. At 7:42 a.m., R2 was observed to be dressed and seated in his wheelchair. NA-G picked up the trash in the room, placed it in R2's wastebasket, and cleaned R2's tray table. NA-G stripped R2's bed and placed the dirty linens in a plastic bag and knotted the top while wearing the same gown which was still open to the front. At 7:48 a.m., NA-G removed her gown and gloves and placed them in R2's wastebasket. She did not perform hand hygiene and did not don another pair of gloves. She removed the liner from the wastebasket, knotted the top of the bag and carried it to the storage room across the hall. NA-G returned to R2's room without performing hand hygiene and gave R2 a washcloth for his face. She put on gloves and carried the sealed bag of dirty linen out of R2's room and placed it in the storage room. She returned to R2's room, removed her gloves, and performed hand hygiene. During an observation on 8/12/26 at 11:14 a.m., NA-G entered R2's room with the Hoyer lift accompanied by NA-F. Both NAs put on a gown and gloves and made up the bed with clean linens. At 11:20 a.m., R2 was transferred to the bed using the Hoyer lift. NA-G told NA-F they needed to check and change R2. At 11:23 a.m., NA-F emptied R2's urinary catheter bag into a plastic bedside urinal and cleaned the tip of the catheter bag with an alcohol wipe. NA-F did not perform hand hygiene or change gloves after emptying the catheter bag or cleaning the tip. At 11:26 a.m., NA-F and NA-G removed R2's soiled brief, cleaned R2's skin with disposable wipes, and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed a clean brief on R2. NA-G removed her gloves, performed hand hygiene, and donned new gloves. NA-F kept her gloves on and did not perform hand hygiene. NA-G placed a pillow behind R2's back and another pillow between his legs. NA-F assisted in adjusting the pillows while wearing the same gloves. At 11:29 a.m., NA-F removed her gown and gloves and left R2's room with the Hoyer lift. She did not perform hand hygiene. NA-F placed the Hoyer lift in the storage room and proceeded down the hall. During an interview on 8/13/26 at 9:51 a.m., NA-D stated she put on a gown and gloves before entering the rooms of any residents on EBP for whom she would be providing direct cares. She removed the gown and gloves prior to exiting the room and either washed her hands or used hand sanitizer. NA-D stated she changed her gloves and performed hand hygiene in the room whenever her gloves became soiled or when she had performed a more high-risk task such as emptying a catheter bag. She stated the purpose of the gown and gloves was to prevent germs from spreading to other residents on her clothes. She said gowns should be worn with the opening in the back and the ties wrapped around to the front. NA-D stated the facility provided annual training on EBP both online and in-person. During an interview on 8/13/26 at 10:31 a.m., NA-G stated she put on a gown and gloves before entering the room of a resident on EBP if she knew she was going to be providing hands-on care to the resident. NA-G said the purpose of the gown was to protect herself and other residents. NA-G stated gowns should be worn with the opening in the back and the strings wrapped around and tied in the front. When asked if she was wearing her gown open to the front on 8/12/26 when providing cares to R2, NA-G stated, Oh, maybe I did. I'm so sorry. NA-G confirmed she would change gloves and perform hand hygiene after emptying a urinary catheter or cleaning the tip of the urinary catheter bag. NA-G stated nursing staff had online EBP training every year and the Director of Nursing (DON) had done an in-person training session a couple months ago. During an interview on 8/13/26 at 11:29 a.m., the DON stated in-service training on EBP was conducted for all nursing staff in May and June. Staff were expected to follow EBP according to the CDC guidelines. The DON stated all nursing staff were expected to don a gown and gloves when a resident was on EBP and they were performing high-contact activities including changing linens, bathing, dressing, transferring, changing briefs, performing catheter care, etc. The DON said gowns are to be worn with the opening to the back. The DON stated she expected gloves to be changed and hand hygiene to be performed if gloves become soiled or after providing any high-contact cares, including transferring a resident, changing linens, performing pericare, and emptying a urinary catheter bag. An undated policy titled Enhanced Barrier Precautions received from the facility on 8/13/26, stated it was the facility's policy to implement EBP for the prevention of transmission of multi-drug resistant organisms (MDROs). The policy outlined specific steps related to staff training, EBP initiation, implementation measures, and examples of MDROs of particular concern. An undated policy titled Hand Hygiene received from the facility on 8/13/26, indicated all staff would perform proper hand hygiene procedures to prevent the spread of infection. The policy outlined when hand hygiene was to be performed and which techniques were to be used in specific circumstances.		