

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2025
NAME OF PROVIDER OR SUPPLIER St Anthony Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 Foss Road Northeast St Anthony, MN 55421	
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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review, the facility failed to update the care plan with specific interventions for 1 of 1 resident (R3) reviewed for falls. Findings include: R3's significant change Minimum Data Set (MDS) dated [DATE], identified R3 had severe cognitive impairment, disorganized thinking, and needed extensive assistance with toileting, bed mobility and transfers. The MDS lacked identification of falls for R3. R3's document titled with R3's name undated, indicated after a fall on 6/8/25, an intervention for PRN medications was put in place. Furthermore, the document indicated after a fall on 6/9/25, interventions for frequent rounding and hospice to review side effect monitoring for medications was put in place. R3's care plan revised 6/20/25, lacked interventions for PRN medications after a fall on 6/8/25 and frequent rounding and hospice to review side effect monitoring for medications after a fall on 6/9/25. During an interview on 7/22/25 at 12:03 p.m., nursing assistant (NA)-A stated she would look in the care plan for any fall interventions in place. During an interview on 7/22/25 at 2:18 p.m., licensed practical nurse (LPN)-A stated he would look in the care plan for any current fall interventions. LPN-A stated the management team was responsible for revising and or adding new interventions to the care plan. During an interview on 7/22/25 at 2:58 p.m., registered nurse (RN)-A stated revised or new interventions for R3's falls on 6/8/25, and 6/9/25, should have been added to the care plan by him and he confirmed he did not add any to the care plan. During an interview on 7/22/25 at 3:30 p.m., the administrator stated staff were to refer to the care plan for fall interventions. The management team was responsible for placing fall interventions into care plans as soon as possible. The facility Post Fall Assessment policy reviewed 10/14/24, indicated changes as appropriate would be made on the resident's care plan and communicated to the nursing staff.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245267
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