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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Health & Rehabilitation	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and interviews, the facility failed to ensure proper usage of personal protective equipment (PPE) while sorting soiled linens and personal laundry. This had the potential to affect all 92 residents residing in the facility.Findings include:During tour of the laundry room on 6/16/26 at 3:17p.m. no PPE was observed anywhere in the dirty linen sorting area.On 6/16/26 at 3:17 p.m. housekeeping supervisor (HS) confirmed staff do not wear the required PPE while sorting soiled laundry. HS stated they will wear gloves but no other items. This had been the practice since they started working in the laundry room the previous year.On 6/16/26 at 3:09 p.m. administrator stated their expectation was staff wore full PPE, including gown, gloves, and goggles while sorting laundry.On 6/16/26 at 3:47 p.m. administrator stated the facility did not have a laundry policy.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure privacy for 1 of 1 resident (R101) reviewed for dignity. Findings include: R101 face sheet indicated admission on [DATE], diagnoses included Urinary Tract Infection, Neuromuscular dysfunction of the bladder, Infection and inflammatory reaction due to indwelling urethral catheter. During observation on 6/17/26 at 10:29 a.m. R101 was ambulating with occupational therapist (OT)-A. An uncovered urinary catheter bag was hanging on the lowest bar of the wheeled walker. R101 and OT-A ambulated down the hallway, past the nurse's station and dining room, to the end of another hall before he sat down to rest. R101 walked past 2 staff and 2 residents. During interview on 6/17/26 at 10:40 a.m. OT-A stated she forgot to move the privacy bag with the catheter bag to the walker. She stated catheter bags should remained covered for resident's privacy. During interview on 6/17/26 at 1:20 p.m. R101 stated preference to have catheter bag covered when in public areas. During interview on 6/17/26 at 1:25 p.m. registered nurse (RN)-A stated catheter bags were to be covered. It's a dignity issue. A catheter policy was requested; however, none was provided.

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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, record review, and interview, the facility failed to follow standards of practice for medication management for 1 of 8 residents (R72) reviewed for medication administration.Findings include:During a medication administration observation on 6/16/26 at 5:20 p.m., it was noted R72's order in the facility's electronic medication administration record (EMAR) indicated R72's Morphine Sulfate order was dispensed as 15 milligram (MG) tablet (TAB) with a dose of 2.5mg to be given sublingually (under the tongue) every (q) 3 hours. However, the Morphine sulfate card from the pharmacy showed the medication was a 2.5mg sublingual tablet to be given q6hrs. Registered nurse (RN)-A confirmed they did not match and tended to happen with sublingual tablet orders.R72's annual minimum data set (MDS) dated [DATE], indicated R72 was admitted [DATE], severely cognitively impaired, and had the following diagnoses: atrial fibrillation (top two chambers of the heart don't pump correctly), coronary artery disease, heart failure, hypertension (high blood pressure), diabetes, Alzheimer's, anxiety, arthritis, and non-Alzheimer's dementia.R72's order summary report printed 6/16/26, indicated R72 had a current order for Morphine Sulfate 15mg tablet- give 2.5mg sublingually q3hr for pain.R72's [provider] Hospice physician orders form dated 6/12/26, indicated the handwritten order from the provider: Morphine 2.5mg solutab: give 1 solutab under the tongue every 3 hours for pain.R72's current medication cards read as follows:-Card #1(lableled #15)-Morphine Sulfate 2.5mg sol tab- 1 tablet orally or sublingually every 6 hours: 1 tablet orally or sublingually every hour as needed. There were no dose change stickers on the card.-Card #2-(lableled #16)-Morphine Sulfate 2.5mg sol tab- 1 tablet orally or sublingually every 6 hours: 1 tablet orally or sublingually every hour as needed. There were no dose change stickers on the card-Care #3-(lableled #17)-Morphine Sulfate 2.5mg sol tab- 1 tablet orally or sublingually every 6 hours: 1 tablet orally or sublingually every hour as needed. There were no dose change stickers on the [NAME] 6/16/26 at 5:20p.m. RN-A confirmed they failed to follow the 5 rights of medication administration, 1-Right person, 2-Right Drug, 3-Right Dose, 4-Right Route, 5-Right time. RN-A confirmed the dose of the tablet and the time on the cards did not match the current order, but as the dose was the same, they continued to use the card. RN-A stated they would normally call the pharmacy and get a card with the correct information sent over, but they had not done that as the dose had matched. Furthermore, RN-A stated they had stickers they can put on the card to alert other staff members to the change in dose, however they had not used the sticker, because they had forgotten.On 6/18/26 at 0910 a.m., pharmacist (PHRM) confirmed R72's orders had a tablet strength of 15mg listed. They stated the wrong dose had most likely been selected when ordering the tablet. PHRM stated they attempted to catch transcription errors during monthly medication review; however, this one had been missed. Their expectation was the cards and the orders matched. It was important to ensure to prevent medication error or overdose.On 6/18/26 at 9:43 a.m. director of nursing (DON) stated the process and expectation for transcribing orders was the order would be written by the provider, given to the health unit coordinator (HUC) to be entered, then reviewed by two nurses to verify the orders. The DON confirmed R72's had been confirmed by two nurses. However, the orders did not match, and they expected staff to have been using the order/dose change sticker. The DON stated the importance of verifying orders were transcribed correctly and the staff were using the 5 rights of medication administration to ensure they provided medications safely and don't have the wrong dose. The facility medication and treatment orders policy dated January 2024, indicated orders for medications and treatments will be transcribed accurately and in a timely manner. Orders must include the following: A: Name and strength of drug B: Number of Doses, start and stop date, and/or specific duration of therapy C: Dosage and frequency of administration D: Route of administration E: Clinical Condition or symptoms for which the medication is prescribed F: Any interim follow-up requirements

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure pharmacy recommendations were addressed for 1 of 5 residents (R13) reviewed for unnecessary medications.Findings include:R13's quarterly minimum data set (MDS) dated [DATE], indicated R13 was admitted [DATE], severely cognitively impaired, and had the following diagnoses: hypertension (HTN) (high blood pressure), renal insufficiency, diabetes, thyroid disorder, non-Alzheimer's dementia, and a stroke.R13's Clinical physician orders printed 6/17/26, indicated R13 was currently prescribed the following HTN medications:Metoprolol Succinate extended release (ER)-50 milligrams (MG) tablet- give 50MG by mouth once daily for HTN. Start date-2/26/26Lisinopril 40MG table- give 1 tablet daily for HTN- start date 2/26/26Amlodipine Besylate 10MG tablet- Give 1 tablet by mouth every night at bedtime for HTN- start date-2/25/26R13's monthly pharmacy recommendation dated 3/13/26, indicated the pharmacist had requested hold parameters for the above medication orders. The document also shows the provider responded and ordered parameters for HOLD if systolic blood pressure (SBP) is 100 or less. The order was signed and reviewed by two different nurses on 3/19/26 and 3/20/26.However, R13's medical record had no evidence the parameters were ever added to the orders.On 6/17/26 at 4:27p.m., the regional nurse consultant (RNC) accessed the facility's electronic charting system and confirmed the parameters of HOLD for SBP less than 100 were never added to any of the 3 orders as directed by the physician. The RNC confirmed that even though the pharmacy recommendation was signed off it was never entered as ordered.On 6/18/26 at 09:10 a.m. pharmacist (PHRM) confirmed the parameters were never entered as ordered. PHRM stated their expectation was the facility addressed and completed the pharmacy recommendations and order changes within 30 to 60 days. The PHRM stated the importance of keeping the orders up to date because it could have had a negative effect on the residents.On 6/18/26 at 9:43 a.m. director of nursing (DON) stated the pharmacy emailed the monthly recommendations to the DON and they passed it on to the nurse managers for each wing. Nurse managers were responsible for following up on the recommendations. DON confirmed the parameter orders for R13 were never entered. Their expectation was it would have been completed as ordered. The DON stated the importance of having blood pressure parameter on blood pressure medications as ordered to prevent the residents blood pressure from dropping too low.The Consultant Pharmacist Reports Policy last revised January 2026 indicated the pharmacy recommendations are acted upon and documented by the facility staff and/or prescriber. The DON or designated licensed nurse address and document recommendations that do not require physician intervention, e.g., monitor blood pressure.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure binding arbitration agreements were clearly communicated in a form and manner residents understood prior to signing for 1 of 3 residents (R43) reviewed for binding arbitration. This had the potential to affect residents who signed binding arbitration prior to 5/1/26. Findings include: R43's admission Minimum Data Set (MDS) indicated admission on [DATE], intact cognition with diagnoses of non-Alzheimer's dementia, and moderate vision impairment (limited vision: not able to see newspaper headlines but can identify objects), and R43 always needed to have someone help with reading written materials. Exhibit H- Binding Arbitration Agreement undated, included signature of R43. During interview on 6/17/26 at 11:23 a.m. R43 stated he would have not signed a binding arbitration agreement. R43 stated legal issues at the time of his admission would have kept him from signing an arbitration agreement. He would never agree to a mediator. He was not able to read or write and would therefore require assistance. During interview on 6/17/26 at 3:19 p.m. social services (SS)-A stated he completed binding arbitration with R43. He explained binding arbitration as a legal form allowing residents to speed up the process when bringing the facility to court. I [SS-A] would not have stated they were giving up any rights. SS-A stated he had limited training on binding arbitration. He was responsible for all binding arbitration agreements until 5/1/26, when it was transferred to the admission coordinator. During interview on 6/17/26 at 3:29 pm. admission coordinator (AC) stated she had recently been hired and presented binding arbitration upon admission. She stated if a resident did not understand, she would stop and discuss binding arbitration with family. On 6/18/26 at 10:00 a.m. Administrator stated all binding arbitration agreements were grandfathered in. A facility document titled Explanation of Arbitration Agreement Language to Family and Resident/Patient indicated arbitration does not occur in a court. however, the document lacked indication the agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. Further, it lacked resident/representative acknowledgement that he or she understands the agreement.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure 2 of 5 residents (R11, R76) were offered, educated and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC), who were reviewed for immunizations.Findings include: A CDC Adult Immunization Schedule by age topic, dated 08/07/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had not received the complete series of pneumococcal vaccination (i.e., PPSV23, PCV20 and PCV13) or their history is unknown, then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20), 1 dose of PCV-15, or PCV-21. R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 was admitted on [DATE], [AGE] years old, severely cognitively impaired, and had the following diagnoses: hypertension (HTN) (high blood pressure), renal insufficiency, diabetes (DM), non-Alzheimer's dementia, depression, malnutrition, and psychotic disorder other than schizophrenia. R11' s undated client information vaccination record indicated R11 was due for their next pneumonia vaccination. R11's immunization informed consent form signed 12/3/25, indicated R11 had given consent to receive the PCV20 vaccination. R11's medical record lacked any evidence the PCV20 was ever provided. R76's quarterly MDS dated [DATE], indicated R76 was admitted on [DATE], [AGE] years old, cognitively intact, and had the following diagnoses: HTN, neurogenic bladder (bladder unable to empty on its own), DM, paraplegia (inability to move one's limbs), seizure disorder, depression, malnutrition, and bipolar disorder. R76's undated client information vaccination record indicated R76 was due for their next pneumonia vaccination. R76's medical record lacked any evidence the PCV20 was ever provided. R76's immunization informed consent form signed 9/23/25, indicated R76 had not been offered the PCV20 vaccination. On 6/16/26 at 3:35 p.m. regional Nurse consultant (RNC) stated she was responsible for infection prevention while the current infection preventionist was on vacation. She confirmed neither R11 or R76 were offered the PCV20, and it had been missed. RNC stated their expectation was for the vaccinations to have been offered and provided upon admission. Furthermore, RNC stated the importance of providing vaccinations according the to the CDC recommendations was to keep the residents healthy. The facility's Pneumococcal policy last revised 2/24, indicated prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident will be offered the vaccine, when indicated, unless the resident had already been vaccinated or the vaccine is medical contraindicated.