



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 30, 2025

Administrator
Little Sisters Of The Poor
330 Exchange Street South
Saint Paul, MN 55102

RE: CCN: 245524
Cycle Start Date: December 11, 2024

Dear Administrator:

On January 29, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 30, 2025

Administrator
Little Sisters Of The Poor
330 Exchange Street South
Saint Paul, MN 55102

Re: Reinspection Results
Event ID: V7Y112

Dear Administrator:

On January 17, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 11, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2024

Administrator
Little Sisters Of The Poor
330 Exchange Street South
Saint Paul, MN 55102

RE: CCN: 245524
Cycle Start Date: December 11, 2024

Dear Administrator:

On December 11, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 March 11, 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 June 11, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2024

Administrator
Little Sisters Of The Poor
330 Exchange Street South
Saint Paul, MN 55102

Re: State Nursing Home Licensing Orders
Event ID: V7Y111

Dear Administrator:

The above facility was surveyed on December 9, 2024 through December 11, 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

December 18, 2024

Administrator
Little Sisters Of The Poor
330 Exchange Street South
Saint Paul, MN 55102

Re: Project Number

Dear Administrator:

The above facility survey was completed on December 11, 2024 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments On 12/9/24 through 12/11/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 12/9/24 through 12/11/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.	F 000			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		1/9/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024	
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR				STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102			
(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 695	Continued From page 1 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen was administered according to physicians orders for 1 of 2 residents (R11) reviewed for respiratory care. Findings include: R11's Optional State Assessment (OSA) dated 10/10/24, indicated moderate cognitive impairment, did not reject cares, did not have shortness of breath, and used oxygen. R11's medical diagnoses form indicated the following diagnosis: pulmonary fibrosis (scarring and thickening of the tissue and between the air sacs in the lungs). R11's physician's orders dated 6/26/24, indicated the following order: oxygen 1 to 6 liters per minute per nasal cannula or mask as needed for dyspnea (shortness of breath keep oxygen saturations greater than 91% and notify the physician). R11's medication administration record (MAR) and treatment administration record (TAR) dated November 2024, indicated R11 used oxygen on 11/1,24, 11/3/24, and 11/7/24. The MAR and TAR lacked information regarding R11's oxygen			F 695	Preparation, submissions, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility does not agree with the alleged deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facilities allegation of compliance. It is the policy of Little Sisters of the Poor to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences. Corrective Action for resident affected: Regarding R11, physician was immediately contacted and resident's orders were clarified and updated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
(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 695	Continued From page 2 saturation levels. R11's MAR and TAR dated December 2024, and printed on 12/11/24, indicated R11 did not use oxygen. Additionally, the MAR and TAR lacked information regarding R11's oxygen saturation levels. R11's O2 Sats Summary form indicated R11's oxygen saturation levels on the following dates: 11/3/24, at 7:27 a.m., R11's oxygen saturation was 93% with oxygen via nasal cannula. 11/3/24, at 12:06 p.m., R11's oxygen saturation was 93% on room air. 11/4/24 at 9:59 a.m., R11's oxygen saturation was 85% on room air and at 11:00 a.m., was 95% with oxygen. 11/5/24 at 1:30 a.m., and 5:10 a.m., R11's oxygen saturation was 95% with oxygen and at 5:15 a.m., was 92% with oxygen. 12/2/24 at 11:22 a.m., R11's oxygen saturation was 93% on room air. 12/9/24 at 8:13 p.m., R11's oxygen saturation was 99% on room air. The O2 Sats Summary form lacked information what R11's oxygen saturation levels were on other dates in November and December to know whether R11 required oxygen or not. R11's nursing progress notes were reviewed and R11 utilized oxygen on the following dates: 11/27/24, oxygen saturations were 82-83% on room air and was placed on 1.5 liters of oxygen. R11's Care Guide form undated, lacked information R11 utilized oxygen. R11's care plan was reviewed and lacked information R11 utilized oxygen.	F 695	Moreover, oxygen saturation levels were reviewed and placed on the MAR and TAR. Corrective Action for others that potentially could be affected: Regarding all other residents, facility policy has been reviewed and updated as necessary. All current residents with oxygen will be reviewed to determine that orders are correct and saturation levels are appropriate. Systemic changes: Nursing staff will be trained on respiratory care. Monitoring process to ensure lasting solutions: The facility will randomly audit 3 residents per month for 3 months to determine that orders are correct, oxygen is being administered appropriately, and saturation levels are being monitored per the orders. Moreover, the Interdisciplinary Team (IDT) will review all new oxygen orders for the next 3 months to ensure accuracy. These results will be reported monthly to the facility QAPI team for the following three months, and based upon the outcomes, the facility will assess the need for further audits. Responsible Party: The Director of Nursing, or designee will be responsible for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024	
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR				STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102			
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F 695	Continued From page 3 During interview and observation on 12/9/24 between 12:45 p.m., and 12:48 p.m., R11's oxygen was not turned on. R11 asked if oxygen was going to be applied because she stated she needed oxygen. R11's call light was activated and at 12:48 p.m., nursing assistant (NA)-A answered R11's call light and stated R11 used oxygen at night when going to bed, but did not need oxygen while up in the chair. During observation on 12/10/24 at 3:02 p.m., R11 was in bed and had oxygen on at 1.5 liters per minute. The MAR and TAR lacked information R11 utilized oxygen. During interview and observation on 12/11/24 at 6:56 a.m., and 6:57 a.m., R11 was in bed and the oxygen was off. NA-A stated at 6:57 a.m., R11 had the oxygen on, but NA-A turned it off. During interview on 12/11/24 between 7:01 a.m., and 7:04 a.m., licensed practical nurse (LPN)-A viewed R11's MAR and TAR and stated R11 did not have oxygen signed off as administered in the MAR and TAR. LPN-A stated R11 wore oxygen at night and the evening shift applied the oxygen. LPN-A stated R11 had oxygen on last night. Further, LPN-A stated she had inquired during report about acknowledging they were applying oxygen every night. During interview on 12/11/24 at 8:33 a.m., the director of nursing (DON) stated she expected staff take oxygen saturations as needed for dyspnea to keep oxygen saturations greater than 91%. A policy, Respiratory Care, dated 3/2024,			F 695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
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F 695	Continued From page 4 indicated oxygen was administered under orders of the attending physician, except in the case of an emergency. Check the resident's oxygen saturations as ordered by the physician.	F 695			
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and implement individualized person centered dementia care for 1 of 2 residents (R2) reviewed for dementia care. Findings include: R2's Clinical Diagnosis form, indicated the following diagnoses: vascular dementia with agitation, age-related macular degeneration, legal blindness, other symptoms and signs involving cognitive functions and awareness, primary generalized osteoarthritis, unilateral primary osteoarthritis of the left knee, aphasia (a language disorder making it difficult to communicate), insomnia, cerebral infarction (stroke) due to embolism (blood clot), type two diabetes mellitus with polyneuropathy (a complication where peripheral nerves are damaged throughout the body), and other cerebrovascular disease (a condition that affects blood flow to the brain).	F 744	It is the policy of Little Sisters of the Poor that a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his/her highest practicable physical, mental and psychosocial well-being. Corrective Action for resident affected: Regarding R2, she will be reassessed to ensure that behavior management is completed and incorporated into an individualized plan of care. In order to develop appropriate interventions, staff are instructed to be vigilant for behaviors that identifies her needs and staff will communicate these observations to the nurse, who in turn, will ensure that needs are addressed in care planning. Based on behavior charting, staff can better identify a root cause analysis and develop interventions to best maintain her mental and psychosocial well-being.	1/9/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024	
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR				STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102			
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F 744	Continued From page 5 R2's Annual Minimum Data Set (MDS) dated 9/19/24, indicated R2 had unclear speech, had short and long-term memory problems, severely impaired cognitive skills for daily decision making, did not have delirium, inattention, disorganized thinking, or altered level of consciousness, did not have hallucinations or delusions, did not have physical symptoms such as hitting, grabbing others, pushing, or scratching, verbal, or other behavioral symptoms and did not reject care. Further, the MDS indicated R2 had an impairment of range of motion to both upper extremities, utilized a wheelchair, was dependent on staff for transfers, oral hygiene, toileting hygiene, showering and bathing, dressing, and personal hygiene, and was always incontinent of bowel and bladder, was at risk for development of pressure ulcers, took antipsychotics, antidepressants and a gradual dose reduction was contraindicated. R2's Area Assessment (CAA) dated 9/19/24, indicated R2 had severe difficulty communicating due to expressive aphasia from a stroke and progressive dementia and staff needed to anticipate all needs. Weepiness, moving self in wheelchair in the hall, or repetitious non intelligible content, and grimaces was R2's way of reporting discomfort. Additionally, R2 had severely impaired cognition and took psychotropic medications for depression and anxiety. The CAA did not trigger for behavior symptoms, or pain. R2's Care Guide undated, indicated R2 transferred with a Hoyer lift, was assist of 2 staff, required the wheelchair at the bedside with the brakes locked, required toileting before and after meals, at bedtime and as needed, had a tub bath on Wednesday and Friday a.m. shift, if agitated			F 744	Corrective Action for others that potentially could be affected: Regarding all other residents, facility policy has been reviewed and updated as necessary. Behavior Monitoring Task force has been formed and will identify all residents with behaviors and reassess in order to create a more individualized plan of care. Moreover, staff are instructed to be vigilant for behaviors that identify a need and staff will communicate these observations to the nurse, who in turn, will ensure that needs are addressed in care planning. Based on behavior charting, staff can better identify a root cause analysis and develop interventions to best maintain the resident's mental and psychosocial well-being. Systemic changes: Facility policy has been reviewed and updated as necessary. Moreover, Facility will create a behavior monitoring task force who will review behaviors on a monthly basis, monitor outcomes and develop future interventions or updates to the plan of care. Finally, nursing staff will be trained on ensuring proper documentation of behaviors, developing care planned interventions based upon those behaviors, and reviewing appropriate medications given the documented episodes. Monitoring process to ensure lasting solutions: The facility will randomly audit 3 residents per month to determine that appropriate behavior charting is being completed and that interventions and care plan are being adjusted. These results		

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F 744	Continued From page 6 staff were to reapproach when calm for activities of daily living and report to the nurse if resident exhibited exit seeking behaviors. Further, the guide indicated R2 had behaviors and staff were to reapproach when agitated and provide time for R2 to calm down. R2's care plan dated 11/15/24, indicated R2 did not always have to have glasses on as R2 may remove glasses in periods of heightened anxiety and agitation. R2's care plan dated 9/18/24, indicated R2 had functional mobilities and unsteadiness with transfers, decreased range of motion in upper extremities and an intervention revised on 12/9/24, indicated R2 was non ambulatory. Other interventions indicated R2 required extensive assist of two staff for bed mobility, Hoyer transfers with two persons, wheelchair at bedside and locked at night, two assist for safety with bathing with getting in and out of the tub, baths completed on Tuesday and Friday morning shift, total assist of 2 with upper and lower body dressing, total assist of one to two in all areas of personal hygiene and oral care, and reapproach for any self care assistance if and when R2 declined. R2's careplan dated 11/13/24, indicated R2 had difficulty falling asleep and wandered and interventions included providing medications for sleep, offering one to one support, snacks, coke as needed, and when R2 was agitated staff were to ensure their safety and reapproach when calm for activities of daily living (ADLs). R2's care plan dated 9/16/24, indicated R2 required assistance to toileting before and after	F 744	will be reported monthly to the facility QAPI team for the following three months, and based upon the outcomes, the facility will assess the need for further audits. Responsible Party: The Director of Nursing, or designee will be responsible for compliance.		

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F 744	Continued From page 7 meals and before bed as R2 accepted. R2's care plan dated 10/16/24, indicated R2 had recurrent MASD (moisture associated skin damage) and interventions indicated to apply moisture barrier creams, assist to reposition every two hours to prevent skin breakdown, offer and assist with toileting and pericare every two hours while awake. R2's care plan dated 9/12/24, indicated R2 could not report pain and had restless legs associated with neuropathy, osteoarthritis, knee replacements, peritoneal adhesions, history of shingles, history of decreased range of motion to the right shoulder rotator cuff, hand and right knee pain, chronic gastrointestinal discomfort. R2's scheduled narcotic was discontinued on 8/5/24. Interventions included observing for pain and notifying the physician as needed for inadequate pain relief, observe for signs of pain such as facial expressions, rubbing at painful area, increased behavioral symptoms because she cannot express pain due to aphasia and cognitive loss and update the physician on neuropathy as needed. R2's behavior care plan dated 11/13/24, indicated R2 was at risk for elopement and was not easily redirectable. Interventions included to assess for falls risk, disguise exits, monitor for fatigue and weight loss, provide activities toileting, walking inside and outside, reorientation strategies, pictures and memory boxes. R2's psychotropic medication care plan dated 9/12/24, indicated R2 started Lexapro an antidepressant on 6/10/22, had Cymbalta discontinued on 6/22, trazodone was decreased	F 744			

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F 744	Continued From page 8 on 3/15/24 for insomnia and restlessness, and Seroquel an antipsychotic was started on 9/29/23, and a dose reduction was contraindicated. Interventions included monitoring and documenting and reporting the physician as needed ongoing signs and symptoms of depression unaltered by antidepressant medications, sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood and comments, slowed movement, agitation, disrupted sleep, fatigue, and lethargy. R2's Physician Orders form indicated the following orders: 6/20/19, acetaminophen 500 mg tablet give 2 tablets by mouth three times a day for chronic pain. 4/29/21, lidocaine patch 4% apply to lower back topically in the morning for lower back pain and remove per schedule. 7/21/21, staff may offer aromatherapy, hand massages, topical analgesic to hands, and one to one time with resident which may help her to cooperate with allowing treatments and activity of daily living (ADL) cares. Staff may reapproach when resident refuses cares every shift for cares and comfort. 6/11/22, escitalopram oxalate 10 mg tablet give 1 tablet by mouth one time a day for depression. 9/23/23, Reapproach resident if she refuses her medications and document all refusals every shift for anxiety and paranoia. 12/5/23, monitor for paranoia and agitation evidenced by behaviors of hitting, screaming, kicking, refusing medications every shift for order of Seroquel. 3/15/24, trazodone 50 mg at bedtime for insomnia.	F 744			

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F 744	Continued From page 9 3/28/24, Seroquel 25 mg (milligrams) give 25 mg by mouth one time a day for agitation and paranoia. Give Seroquel in the evening. 3/28/24, gabapentin 300 mg by mouth in the evening for neuropathy pain. 3/28/24, document all behaviors for resident hitting, kicking, scratching, resistive to cares, pushing nurses hands, and any other behavior resident exhibits every shift for cognition. 7/16/24, Voltaren external gel 1% apply to both knees topically two times a day for pain apply two grams. 11/18/24, Voltaren external gel 1% apply to back and both hips topically two times a day for fall. Apply 2 grams to back and bilateral hips twice daily. R2's 30 day behavior symptoms task form printed 12/11/24 at 12:34 p.m., indicated R2 had no documented behaviors in the past 30 days. R2's nursing progress note dated 11/23/24, at 2:03 p.m., indicated, "ok to use Hoyer lift assist of 2-3 with one staff to engage resident in attempt to ease anxiety. If any signs of resistance/aggression/fighting-do not use Hoyer. every shift for Transfer protocol. Using EZ stand". R2's nursing progress notes from 11/1/24, to 12/11/24, were reviewed and indicated R2 displayed behaviors or agitation on 11/8/24, 11/12/24, 11/14/24, 11/28/24, 12/4/24, and 12/11/24. R2's physician progress note dated 8/5/24, indicated R2 could not communicate verbally and agitation was similar in the past months with increased confusion and R2's oxycodone (opioid	F 744			

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F 744	Continued From page 10 pain medication) was recently decreased, and moved both hips, knees and ankles without any pain. R2 had dementia, and agitation and agitation was improved with a scheduled low dose oxycodone and Seroquel, further the note indicated to continue the low dose of oxycodone 2.5 mg three times a day. R2's physician progress note dated 9/30/24, indicated R2's behavior was stable oxycodone dose was decreased, and to continue on Plavix and Seroquel. R2's physician progress note dated 11/11/24, indicated agitation was similar in the past months with increased confusion and R2's oxycodone was recently decreased, and moved both hips, knees, and ankles without any pain. Further R2 had agitation and plan to continue on Plavix and Seroquel as behavior was stable. During interview and observation between 12/9/24 at 1:18 p.m., to 1:26 p.m., R2 was heard yelling in her room. Nursing assistant (NA)-B stated she worked at the facility about 4 months and they planned to toilet R2. NA-A stated when R2 transferred from bed to chair, they used a Hoyer lift and they used a stand lift because it was too difficult to tuck in the Hoyer sling because R2 fights. Staff brought in the EZ stand lift and stated it was part of the plan of care because it was so difficult to apply the sling for the Hoyer and was their only choice because R2 was combative. NA-A stated she had worked at the facility for 15 years. At 1:26 p.m., R2 was vocalizing and staff stopped and took out the stand lift and stated they would come back and did not transfer R2.	F 744			

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F 744	Continued From page 11 During interview and observation on 12/9/24 from 1:59 p.m., to 2:12 p.m., NA-A and NA-B brought the EZ way stand lift into R2's room. At 2:01 p.m., the sling was placed behind R2's back and R2 was hitting at staff when trying to put the sling under R2's arm. At 2:02 p.m., staff put R2's legs on the lift and R2 started making repetitive vocalizations, I, I, I, I, and was pushing the EZ lift away. R2's legs were strapped in the lift. At 2:03 p.m., staff attached the sling and instructed R2 to hold the handles and R2 grabbed the handles of the lift on the left and right side and resident kept stating I, I, I, I, and was transferred from the chair to the bed and R2's vocalizations slowed but continued yelling, I, I, I. R2 was positioned on the left side and vocalizations stopped. AT 2:06 p.m., staff started helping to change R2's pants and R2 began yelling out again and kicking her legs. Vocalizations stopped when staff completed the task. Staff engaged R2 with her stuffed animals and changed her brief at 2:07 p.m., and R2 was pushing away with the repetitive vocalizations. NA-A was trying to apply a new brief and R2 began hitting at NA-A. At 2:10 p.m., R2 was covered and the bed was lowered. R2 was not vocalizing and the wheelchair was placed by NA-A at the bedside but not locked. NA-B locked the brakes on the wheelchair at 2:11 p.m., and NA-A wiped down the EZ stand lift. At 2:12 p.m., R2 was quiet. NA-A stated registered nurse (RN)-A directed staff to use the EZ stand and further stated she spoke with RN-A about a month ago because the care plan indicated a Hoyer lift. NA-A stated RN-A observed them and further NA-A stated it was an every day struggle with R2 to toilet R2 because of her sling and added R2 holds the EZ stand and stands up and further stated they placed a chair by R2's bed because R2 tries to stand up and self transfer.	F 744			

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F 744	Continued From page 12 During observation on 12/10/24 at 8:37 a.m., licensed practical nurse (LPN)-A introduced herself to R2 and offered her medication. R2 was softly stated, doe, doe, doe, doe. LPN-A gave the medication on a spoon to R2 and R2 put the medication into her mouth. During observation on 12/10/24 at 10:24 a.m., NA-A was pushing R2 in her wheelchair and R2 was making nonsensical vocalizations. During observation on 12/10/24 at 3:11 p.m., R2 was in bed and was not making any vocalizations. During observation on 12/11/24 at 7:21 a.m., R2's room was dark except the bathroom light was on and the curtain was pulled in R2's room. R2 was in bed and was not making any vocalizations. During interview on 12/11/24 at 9:24 a.m., NA-A stated she knew what kind of cares a resident received based on the care guide and stated R2 was dependent for cares and was a Hoyer lift now and two assist for everything because it was difficult R2 was combative every day and at night, R2 sleeps, but in the mornings, R2 does not want to be bothered and makes noises. NA-A stated R2 becomes upset when she is touched or when she is undressed, becomes angry and kicks and stated R2 was like that every day and only with the activities of daily living and when in the chair was fine and further stated it has been going on a while and was especially difficult on Wednesdays and Saturdays because it was R2's bath days and added R2 was probably in pain and stated the nurse documented behaviors and the NA's also had to document.			F 744			

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F 744	Continued From page 13 During interview on 12/11/24 at 9:19 a.m., NA-C stated they looked to the care plan to know what cares a resident required and stated R2 hits if she doesn't sleep well and stated she was very aggressive and that was why they were letting her sleep in, but did not know how often R2 had behaviors because she did not normally work on this floor. During interview on 12/11/24 at 9:09 a.m., registered nurse (RN)-A stated R2 was supposed to be transferred with a Hoyer lift and stated she was aware staff used the EZ stand and saw the transfer as safe. RN-A stated R2 did not like physical care and when talking with her R2 will calm down and most of the time got upset and did not like toileting, and bathing and added even though R2 beats us up, R2 was sweet. RN-A stated behaviors should always be documented and added the NA's document in the medical record and report to nurses and then the nurse can document the behavior in the medical record. RN-A stated it was important to document because R2 was on Seroquel and they needed to see what behaviors R2 had and the necessity of the drug. RN-A stated overall R2's behaviors still existed and was not sure why R2 was combative with cares but did have long standing insomnia and stated overall, R2's behavior was better. During interview on 12/11/24 at 10:33 a.m., the director of nursing (DON) stated behaviors should be documented right after they occur. Staff would finish their task first and then document when the situation was safe to do so. The DON further stated it was important to document behaviors to have the documentation to see if there were any patterns and they could look at the root cause to find what triggered the behaviors and come up	F 744			

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F 744	Continued From page 14 with interventions that help the resident whether they are cold, hot, hungry, tired, or in pain. The DON viewed the NA task form and verified there were no behaviors documented in the 14 day look back period. The DON further stated she was aware they had a problem with behavior documentation. A policy, Behavior Management, dated August 2017, indicated all behavior was an attempt to communicate a need and some behaviors interfered with the giving of safe care. Staff will be constantly vigilant for behaviors of residents that communicate a need and staff will communicate these observations to the nurse, who in turn will see that needs are addressed in care planning. Medications and environmental interventions may be utilized in managing the need underlying the behaviors. Problem behaviors are behaviors that either occur frequently and disrupt care or occur infrequently, but pose a serious safety concern for the resident and or staff. Staff is to record each occurrence or a shift total of behaviors for residents. Care-giving staff is to communicate with the nurse about the occurrence of target behaviors. It is the responsibility of the nurse to document on the behavior tracking sheet and an entry is made each time a target behavior occurs and if there is no entry, it is assumed that the behavior did not occur on a particular shift.	F 744			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		1/9/25	

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F 756	Continued From page 15 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon timely for 2 of 5 residents (R2, R29) reviewed for unnecessary	F 756			
			It is the policy of the Little Sisters of the Poor that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist.		

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F 756	Continued From page 16 medications. Findings include: R2's annual Minimum Data Set (MDS) dated 9/19/24, indicated R2 had a short-term and long-term memory problem, did not have physical, verbal, or other behavioral symptoms, did not reject cares, had diagnosis of non-traumatic brain dysfunction, hypertension (high blood pressure), diabetes mellitus, aphasia (a disorder that affects how you communicate), and non-Alzheimer's dementia. Further, R2 had applications of ointments and medications other than to feet, and R2 took an antipsychotic. R2's physician orders indicated the following orders: 7/29/21, nystatin powder apply to affected areas topically as needed for moist, abdominal, groin, breast folds that become red or odorous add routine for 7 to 10 days when rash recurs and continue as needed dose after treatment completed. 1/15/24, nystatin powder apply to abdomen fold topically two times a day for moist fold. R2's medication administration record (MAR) and treatment administration record (TAR) dated December 2024, indicated R2 was receiving nystatin powder twice daily in the morning and p.m. R2's pharmacy consultation report dated 10/17/24, indicated R2 received a topical antifungal, nystatin powder apply to abdomen fold topically two times a day for moist fold for greater			F 756	Corrective Action for those affected: Regarding R2 and R29, drug recommendation made by pharmacist were immediately reviewed and updated. Corrective Action for others that potentially could be affected: Facility has reviewed and revised policy and procedures for pharmacy reviews and irregularities. The Facility will review all 4th quarter recommendations to ensure that all previous recommendations were reviewed and followed. Systemic changes: Facility has reviewed and revised its policy and procedure for pharmacy reviews. Nurses will be educated to ensure that pharmacy reviews are timely and irregularities are being acted upon as directed by the Physician. Monitoring process to ensure lasting solutions: Facility will complete a monthly audit for 3 months to ensure that all pharmacy recommendations are being addressed timely and any irregularities have been acted upon. These results will be reported monthly to the facility QAPI team for the following three months, and based upon the outcomes, the facility will assess the need for further audits. Responsible Party: The Director of Nursing, or designee will be responsible for compliance.		

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F 756	Continued From page 17 than 8 weeks without a stop date. Of note, R2 also has an order for nystatin powder apply to affected areas topically as needed for moist, abdominal/groin/breast folds that become red or odorous add routine for 7 to 10 days when rash recurs and continue as needed (PRN) dose after treatment completed. The pharmacist consultant recommended re-evaluating the ongoing topical antifungal use because prolonged use may increase the risk of adverse consequences, including the development of drug resistant organisms. Under the heading, Physician's Response, was undocumented and there was no physician signature to indicate the medication was addressed with the physician. During interview on 12/11/24 at 9:00 a.m., the director of nursing (DON) stated the previous DON didn't follow up on previous recommendations from October. During interview on 12/11/24 at 12:09 p.m., the pharmacist consultant (PC) stated each month she includes a pending report indicating which reports are not followed up on and spoke with the director of nursing (DON) and realize there has been a delay in getting the recommendations done and further, state anything over 30 days or more were being worked on to get completed. R29's Optional State Assessment (OSA) dated 9/11/24, indicated R29 had depression and took an antidepressant. R29's Medical Diagnosis form indicated R29 had major depressive disorder. R29's Physician's Orders form indicated the following order:			F 756			

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F 756	Continued From page 18 3/20/24, duloxetine oral capsule delayed release particles, give 60 milligrams (MG) by mouth in the evening related to major depressive disorder. R29's MAR and TAR dated December 2024, indicated R29 received duloxetine every 5:30 p.m. R29's pharmacy consultation report dated 9/18/24, indicated R29 received duloxetine 60 mg every p.m., for depression since admission 3/2024. Progress note dated 5/20/24, indicated depression was stable and Federal regulation required an evaluation for dose reduction because dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence and recommended a gradual dose reduction (GDR) for duloxetine. Under the heading, Physician's Response, was undocumented and there was no physician signature to indicate the medication was addressed with the physician. During interview on 12/11/24 at 12:13 p.m., the PC stated she would have expected follow up on the recommendation within 60 days and stated she resent the recommendation on 12/10/24. During interview on 12/11/24 at 8:41 a.m., the DON stated pharmacy recommendations were not being followed up on prior to November and did not know why they were not completed and stated R29's GDR was not followed up on, but going forward have a new process. A policy, Medication Regimen Review, dated March 2017, indicated each resident would have a medication regimen review by a licensed	F 756			

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F 756	Continued From page 19	F 756			
F 757 SS=D	pharmacist. Irregularities identified would be documented on a separate, written report and sent to the attending physician, medical director, and director of nursing, listing the resident name, relevant drug and irregularity the pharmacist identified. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a topical antibiotic was transcribed as written and further failed to ensure the topical antibiotic was still necessary for 1 of 1 residents (R14) reviewed for antibiotic use.	F 757	It is the policy of Little Sisters of the Poor to ensure that each resident's drug regimen is free from unnecessary drugs. Corrective Action for resident affected:	1/9/25	

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F 757	Continued From page 20 Findings include: R14's quarterly MDS dated 11/28/24, indicated R14 was cognitively intact and had diagnoses of diabetes and hidradenitis suppurativa (disease causing puss filled boils on the skin). Furthermore, R14 was on an antibiotic. R14's dermatology provider note dated 5/23/23, indicated R14 was seen for a skin check. The note indicated R14s hidradenitis was clear and ordered R14 to continue the clindamycin lotion (antibiotic) for 1 year. R14's active provider orders indicated on 2/14/22, R14 required clindamycin phosphate 1% lotion to be applied to the abdomen/groin topically for hidradenitis. R14's clindamycin order had no end date. R14's medication administration record (MAR) dated 12/2024, indicated clindamycin 1% lotion as an active order. The MAR further indicated it was unknown if R14 was using the medication as she was able to self-administer and store medications unsupervised. A review of R14's nursing progress notes indicated: -on 11/25/24 at 11:02 p.m., R14's skin was warm and intact with no skin concerns. -on 11/25/24 at 4:26 p.m., R14 had no skin issues. -on 12/2/24 at 9:17 p.m., R14 had no skin issues. -on 12/9/24 at 10:28 p.m., R14 had no new skin issues. R14's care plan revised 11/29/24, lacked	F 757	Regarding R14, the antibiotic lotion was immediately discontinued. Treatment error report completed, physician updated and new dermatology appointment scheduled. Corrective Action for others that potentially could be affected: Facility has reviewed and revised policy and procedures for proper monitoring of medication usage. In the future, the antibiotic list will be provided to Nurse Leadership who will cross reference at the facility level. Nurses will be educated regarding stop dates and antibiotic stewardship. Systemic changes: Facility has reviewed and revised its policy and procedure for proper monitoring of medication usage. Nurses will be educated regarding stop dates and antibiotic stewardship. Monitoring process to ensure lasting solutions: Facility will complete a monthly audit of medication reviews for 3 months to ensure that all pharmacy irregularities and antibiotic time-outs are being addressed as prescribed. These results will be reported monthly to the facility QAPI team for the following three months, and based upon the outcomes, the facility will assess the need for further audits. Responsible Party: The Director of Nursing, or designee will be responsible for compliance.		

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F 757	Continued From page 21 indication R14 was prescribed an antibiotic. When interviewed on 12/10/24 at 12:53 p.m., R14 stated they had "tumor like" things on their groin area and that was why they were taking the clindamycin lotion. R14 verified they were still taking it daily. R14 further stated staff had been unable to get a refill and so she was working with her dermatologist. R14's dermatologist has said they would give 2 more refills but would not do any more until seen again. R14 stated once starting the clindamycin they were able to feel the little pockets under her skin but stated everything else cleared up "right away". R14 stated when she had trouble getting it refilled, she was using the lotion "every other day or so" so it would last. R14 stated during the time of taking it sparingly, her skin had no change. R14 stated the facility or provider had not talked about any risks of long-term antibiotic use. When interviewed on 2/10/24 at 2:22 p.m., registered nurse (RN)-B stated when residents on antibiotics required monitoring of symptoms and tracking to determine if they are improving. This was documented as a progress note. When a resident has a topical antibiotic, the nurse would then monitor the skin. RN-B was not aware R14 was on the clindamycin topical ointment but verified the order and noted there was no end date. RN-B was not aware of any skin altercations or infections for R14 and wasn't sure if the antibiotic lotion was needed. RN-B stated R14 used an outside provider and it was more difficult as R14 handled her own medications. When interviewed on 12/10/24 at 2:50 p.m., with the infection preventionist (IP) and the Director of Nursing (DON), the IP verified R14's antibiotic	F 757			

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F 757	Continued From page 22 was not included in the facility's tracking for antibiotic. IP stated this was not currently tracked and would need to investigate it further. When interviewed on 12/11/24 at 12:18 p.m., the Director of Nursing (DON) verified R14's dermatology note indicated the clindamycin lotion was to be used for a year and the order should have expired in 5/2024. DON was not sure R14 still required the medication and stated a risk and benefit was needed if she wanted it continued. R14 managed her medications and communications with the dermatologist and the DON stated collaboration was sometimes challenging. Furthermore, DON verified the antibiotic list the IP had been pulling from the electronic medical record was only oral antibiotics and had not included topical. DON expected all antibiotics to be tracked for residents in the facility. A facility policy titled Antibiotic Stewardship Policy 2024, directed the provider to ensure a duration was included in an antibiotic order. Furthermore, the policy directed the nurse to monitor and evaluation the effectiveness of the antibiotic and the residents response to the antibiotic to identify if the antibiotic was still indicated.	F 757			
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician,	F 773			1/9/25

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F 773	Continued From page 23 physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure physician notification of an abnormal lab for 1 of 1 resident (R29) reviewed for diabetes. Findings include: R29's Optional State Assessment (OSA) dated 9/11/24, indicated intact cognition, had diabetes mellitus, and received insulin injections 7 of 7 days. R29's Admission Orders form dated 3/19/24, indicated a check box, "Yes" R29 could use Standing House Orders. Directly under the line, May use Standing House Orders, indicated a heading, Diabetes Mellitus Standing Orders If Applicable, with check boxes for "Yes", "No", or "N/A". None of the check boxes were marked. A form, Standing Orders for Skilled Nursing Facilities revised 2023, indicated the following standing orders for diabetes management: Notify the provider if two BG (blood glucose) results are less than 70 or greater than 400 in a 24 hour timeframe and or change in condition; if no condition change, notify provider on the next business day. For a BG less than 70, if patient is symptomatic, administer 6 ounces of fruit juice, milk, other high carbohydrate beverage, or glucose tabs or gel	F 773	It is the policy of Little Sisters of the Poor to provide laboratory services when ordered by a physician and promptly notify the physician as necessary. Corrective action for resident affected: Regarding R29, the Medical Director immediately clarified the blood glucose orders to notify physician of blood glucose greater than 450 and less than 60. Orders were immediately reviewed with nursing staff. Corrective Action for others that potentially could be affected: Facility has reviewed and revised policy and procedures for diabetic orders and physician notification of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures or per the physician's orders. All current diabetic orders will be reviewed to ensure that orders are being followed and physicians are being contacted when blood sugars are outside parameters. Systemic changes: Facility has reviewed and revised policy and procedures for diabetic orders and physician notification of laboratory results that fall outside of clinical reference ranges in accordance		

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F 773	Continued From page 24 orally and if after 2 attempts to treat and BG is still less than 70, notify provider. A form, Diabetes Mellitus Standing Orders form dated 1/2010, directed, treatment for residents able to swallow or with a feeding tube as follows: For hypoglycemia (Blood sugar less than 70) Give 15 grams of glucose or 8 ounces of fruit juice, have resident rest, check BG in 15 minutes and if still below 70, repeat these steps. On the third test if blood sugar is still below 70 and resident continues to be alert and able to swallow, check equipment, clean meter if possible, check for accuracy, and look at the date and appearance of blood sugar strips. If all of these tests appear correct, give resident 115 grams of Glucose. On the fourth test, if blood sugar is below 70, notify the nurse practitioner or physician. A form, Guidelines for Action, Notification and Documentation dated March 2013, indicated the following guidelines for blood glucose and signs and symptoms of hypoglycemia: Notify the physician if BG is still up or down after rechecking and or intervention for gradual increase or decrease notify physician with routine call. Under a heading, Comments, follow diabetes standing orders if appropriate. R29's physician's orders indicated the following orders: 3/20/24, blood glucose (BG) before meals related to diabetes mellitus at 7:30 a.m., 11:30 a.m., and 1730 a.m. 4/2/24, Insulin lispro 100 unit/milliliter (ML) inject 12 units subcutaneously in the morning before breakfast, 20 units subcutaneously before lunch, and 10 units with supper.	F 773	with facility policies and procedures or per the physician's orders. Moreover, Facility is reviewing a more consistent process of standing house orders and in the future, will be using the MAGIC (Minnesota Association of Geriatric Inspired Physicians) standing house orders format for all residents. Monitoring process to ensure lasting solutions: Facility will conduct a random monthly audit for 3 months of diabetic orders to ensure that physician orders are being followed and physicians are contacted when blood sugars are outside parameters. These results will be reported monthly to the facility QAPI team for the following three months, and based upon the outcomes, the facility will assess the need for further audits. Responsible Party: Director of Nursing, or designee, is responsible to ensure compliance.		

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F 773	Continued From page 25 9/30/24, Lantus (a long acting insulin) 100 unit/milliliter (ML) inject 60 units subcutaneously at bedtime for diabetes. 12/10/24 at 4:15 a.m., Hypoglycemic (low blood glucose) (BG) less than 70. Administer 6 ounces fruit juice, milk, other high carbohydrate beverage, or glucose tabs, gel orally repeat BG after 15 minutes, if less than 70, notify the provider as needed for diabetic management and treatment. R29's medication administration record (MAR) and treatment administration record (TAR) dated December 2024, indicated R29 received Lispro insulin with supper, and received Lantus insulin at bedtime on 12/9/24. The MAR and TAR indicated on 12/10/24, at 7:30 a.m., R29's blood glucose (BG) was 78. R29's Blood Sugar Summary report indicated the following BG levels: 12/10/24 at 4:00 a.m., 52 milligrams (MG)/Deciliter (DL). 12/10/24 at 4:07 a.m., 75 mg/dl. 12/10/24 at 4:29 a.m., 114 mg/dl. 12/10/24 at 4:31 a.m., 129 mg/dl. 12/10/24 at 7:00 a.m., 69 mg/dl. 12/10/24 at 7:20 a.m., 62 mg/dl. 12/10/24 at 8:45 a.m., 149 mg/dl. 12/10/24 at 12:33 p.m., 129 mg/dl. R29's care plan dated 11/15/24, indicated R29 had diabetes and interventions included to monitor, document, and report to physician as needed signs and symptoms of hypoglycemia (low BG) such as sweating, and tremors, increased heart rate, pallor, nervousness, confusion, slurred speech.	F 773			

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F 773	Continued From page 26 R29's nursing progress notes dated 12/10/24 at 4:17 a.m., indicated R29's Dexcom (a company that specializes in continuous glucose monitoring) alarm was sounding and R29's BG level was 52 mg/dl. R29 requested orange juice and a glucose tablet and R29's BG was rechecked with a glucometer that indicated BG was 75 mg/dl. R29 had symptoms of being "SHAKEY". R29 drank orange juice, had 2 glucose tablets and at 4:25 a.m., the Dexcom reading was 114 and shakiness was better. R29's license practical nurse (LPN)-A's nursing progress notes dated 12/10/24 at 7:17 a.m., indicated R29's BG at 7:00 a.m., was 69 and R29 requested a glucose tablet. At 7:25 a.m., R29's blood glucose was 62 and at 7:45 a.m., blood glucose was 78 and R29 reported feeling "dizzy". The note further indicated R29 admitted she did not eat her snack the previous evening due to feeling too full. The note lacked information the physician was notified of the low BG. During interview on 12/11/24 at 7:32 a.m., licensed practical nurse (LPN)-A stated with labs you want to be timely on what you need to call the doctor for. LPN-A stated if you have to notify the physician, the notification is documented in the progress notes. LPN-A stated the guidance indicated it was the nurses discretion at notifying the physician and stated they used the standing orders and hypoglycemia was a BG less than 70. LPN-A further stated if after 2 attempts to treat and the BG was still less than 70 the physician should be notified and stated she did not notify the physician. LPN-A viewed R29's medical record and verified there was no documentation to indicate the physician was notified.	F 773			

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F 773	Continued From page 27 During interview on 12/11/24 at 8:41 a.m., the director of nursing (DON) verified R29 could use standing house orders and stated staff should have notified the physician and it was important to notify the physician because it could indicate a change in condition, it could be a sign something is not correct such as not eating snacks and the physician could order changes in insulin, maybe the resident is not eating and the doctor may order further labs. During interview on 12/11/24 between 10:19 a.m., and 10:20 a.m., the DON stated their medical director clarified the blood glucose orders for R29 today to notify the physician of a blood glucose greater than 450 and less than 60. The DON further stated they were working on cleaning up the standing orders and the medical director wanted to look at everything.	F 773			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812			1/9/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024	
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR				STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102			
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F 812	Continued From page 28 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure open refrigerated items were dated and covered. Furthermore, the facility failed to ensure expired items were removed from storage. This had the potential to impact all 32 residents residing in the facility. Findings include: An observation on 12/9/24 at 11:40 a.m., the main kitchen was reviewed. A walk-in refrigerator contained an open package of Hillshire Farm sliced turkey lunchmeat. The lunchmeat was wrapped in saran wrap and had no label or date. At 11:57 a.m., the walk-in dairy refrigerator was reviewed. The refrigerator contained 4 half gallons of Kemps 2% milk. The best by date for all 4 containers was 12/1/24. Dietary aide (DA)-A verified the expired milk and stated they should be thrown away. At 11:59 a.m., the DietaryDirector entered the refrigerator and verified the expired milk. Dietary Director stated they were aware the date was close and didn't realize it had been expired for that long. after reviewed the date verified that date was a while back. At 12:04 p.m., an upright freezer was reviewed in the main kitchen. In the freezer was a tray of vanilla ice cream served up in parfait cups. They were not covered or dated and appeared to be freezer burnt. When interviewed at 12:07 p.m., cook-A verified the sliced lunchmeat contained no date of when it			F 812	It is the policy of Little Sisters of the Poor to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Corrective action for residents potentially affected: Regarding all residents, the facility will review and revise the policy related to dating of foods, proper storage of food and managing expired items. Facility will audit the entire kitchen to ensure proper dating and storage of food is being conducted and all expired items have been removed from storage. Systemic changes: The facility will review and revise the policy on dating of foods, proper storage of food and managing expired items. All dietary staff will be trained to ensure that opened foods are always dated and enclosed properly. Moreover, training will occur regarding expired items and ensuring that they are discarded immediately. Monitoring process to ensure lasting solutions: Administrator and Dietary Manager will conduct weekly audits of the kitchen in month 1, bi-weekly audits of the kitchen during month 2 and a monthly audit of the kitchen during month 3 to determine proper dating, storage and removal of expired items. Additional audits will occur based upon results.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024	
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F 812	Continued From page 29 was opened. Cook-A was not sure when it was opened and further stated a date should've been placed. Cook-A further verified the ice cream and stated they must have been served up over the weekend. Cook-A stated the ice cream should be covered and dated. Cook-A stated the dietary director or himself review for expired items and remove them as they were found. An observation on 12/10/24 at 11:25 a.m., the 3rd floor kitchenette was reviewed. The refrigerator contained an unopened container of Hormel thicken-it juice. The use by date was 9/14/24. When interviewed on 12/10/24 at 11:30 a.m., DA-B verified the expired thicken-it juice. DA-B wasn't sure why it was still in the refrigerator and removed it. DA-B further stated dietary staff reviewed items to ensure none were expired weekly and the juice must have been missed. When interviewed on 12/11/24 at 7:45 a.m., the Dietary Director acknowledged there were some improvements needed for food storage and further stated with the census being lower, items were not getting used as frequently. Dietary Director expected staff to be reviewing refrigerators for expired items and removing them when found. Dietary Director further expected all opened food items to be covered, labeled, and dated. When interviewed on 12/11/24 at 10:46 a.m., the Administrator expected expired items to be discarded and all opened items should be covered and labeled. A facility policy titled Accepting Food Deliveries no date, directed staff to properly covered, labeled			F 812	These results will be reported monthly to the facility QAPI team for the following three months, and based upon the outcomes, the facility will assess the need for further audits. Responsible Party: Administrator, or designee, is responsible to ensure future compliance.		

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F 812	Continued From page 30 and dated and stored as appropriate.	F 812			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
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3 000	INITIAL COMMENTS *****ATTENTION***** BOARDING CARE HOME 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 12/9/24 through 12/11/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure.	3 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

12/23/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
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3 000	Continued From page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software for Minnesota Rules, Chapter 4655 for Boarding Care Homes. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	3 000			
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	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 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 12/9/24 through 12/11/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000			

Minnesota Department of Health

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2 000	Continued From page 3 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director	21530			1/9/25

Minnesota Department of Health

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21530	Continued From page 4 of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon timely for 2 of 5 residents (R2, R29) reviewed for unnecessary medications. Findings include: R2's annual Minimum Data Set (MDS) dated 9/19/24, indicated R2 had a short-term and long-term memory problem, did not have physical, verbal, or other behavioral symptoms, did not reject cares, had diagnosis of non-traumatic brain dysfunction, hypertension (high blood pressure), diabetes mellitus, aphasia (a disorder that affects how you communicate), and non-Alzheimer's dementia. Further, R2 had applications of ointments and medications other	21530	Corrected		

Minnesota Department of Health

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21530	Continued From page 5 than to feet, and R2 took an antipsychotic. R2's physician orders indicated the following orders: 7/29/21, nystatin powder apply to affected areas topically as needed for moist, abdominal, groin, breast folds that become red or odorous add routine for 7 to 10 days when rash recurs and continue as needed dose after treatment completed. 1/15/24, nystatin powder apply to abdomen fold topically two times a day for moist fold. R2's medication administration record (MAR) and treatment administration record (TAR) dated December 2024, indicated R2 was receiving nystatin powder twice daily in the morning and p.m. R2's pharmacy consultation report dated 10/17/24, indicated R2 received a topical antifungal, nystatin powder apply to abdomen fold topically two times a day for moist fold for greater than 8 weeks without a stop date. Of note, R2 also has an order for nystatin powder apply to affected areas topically as needed for moist, abdominal/groin/breast folds that become red or odorous add routine for 7 to 10 days when rash recurs and continue as needed (PRN) dose after treatment completed. The pharmacist consultant recommended re-evaluating the ongoing topical antifungal use because prolonged use may increase the risk of adverse consequences, including the development of drug resistant organisms. Under the heading, Physician's Response, was undocumented and there was no physician signature to indicate the medication was addressed with the physician.	21530			

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21530	Continued From page 6 During interview on 12/11/24 at 9:00 a.m., the director of nursing (DON) stated the previous DON didn't follow up on previous recommendations from October. During interview on 12/11/24 at 12:09 p.m., the pharmacist consultant (PC) stated each month she includes a pending report indicating which reports are not followed up on and spoke with the director of nursing (DON) and realize there has been a delay in getting the recommendations done and further, state anything over 30 days or more were being worked on to get completed. R29's Optional State Assessment (OSA) dated 9/11/24, indicated R29 had depression and took an antidepressant. R29's Medical Diagnosis form indicated R29 had major depressive disorder. R29's Physician's Orders form indicated the following order: 3/20/24, duloxetine oral capsule delayed release particles, give 60 milligrams (MG) by mouth in the evening related to major depressive disorder. R29's MAR and TAR dated December 2024, indicated R29 received duloxetine every 5:30 p.m. R29's pharmacy consultation report dated 9/18/24, indicated R29 received duloxetine 60 mg every p.m., for depression since admission 3/2024. Progress note dated 5/20/24, indicated depression was stable and Federal regulation required an evaluation for dose reduction because dose reductions should occur in modest increments over adequate periods of time to	21530			

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21530	Continued From page 7 minimize withdrawal symptoms and to monitor symptom recurrence and recommended a gradual dose reduction (GDR) for duloxetine. Under the heading, Physician's Response, was undocumented and there was no physician signature to indicate the medication was addressed with the physician. During interview on 12/11/24 at 12:13 p.m., the PC stated she would have expected follow up on the recommendation within 60 days and stated she resent the recommendation on 12/10/24. During interview on 12/11/24 at 8:41 a.m., the DON stated pharmacy recommendations were not being followed up on prior to November and did not know why they were not completed and stated R29's GDR was not followed up on, but going forward have a new process. A policy, Medication Regimen Review, dated March 2017, indicated each resident would have a medication regimen review by a licensed pharmacist. Irregularities identified would be documented on a separate, written report and sent to the attending physician, medical director, and director of nursing, listing the resident name, relevant drug and irregularity the pharmacist identified. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these	21530			

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21530	Continued From page 8 measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530			
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure a topical antibiotic was transcribed as written and further failed to ensure the topical antibiotic was still necessary for 1 of 1	21540	Corrected	1/9/25	

Minnesota Department of Health

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21540	Continued From page 9 residents (R14) reviewed for antibiotic use. Findings include: R14's quarterly MDS dated 11/28/24, indicated R14 was cognitively intact and had diagnoses of diabetes and hidradenitis suppurativa (disease causing puss filled boils on the skin). Furthermore, R14 was on an antibiotic. R14's dermatology provider note dated 5/23/23, indicated R14 was seen for a skin check. The note indicated R14s hidradenitis was clear and ordered R14 to continue the clindamycin lotion (antibiotic) for 1 year. R14's active provider orders indicated on 2/14/22, R14 required clindamycin phosphate 1% lotion to be applied to the abdomen/groin topically for hidradenitis. R14's clindamycin order had no end date. R14's medication administration record (MAR) dated 12/2024, indicated clindamycin 1% lotion as an active order. The MAR further indicated it was unknown if R14 was using the medication as she was able to self-administer and store medications unsupervised. A review of R14's nursing progress notes indicated: -on 11/25/24 at 11:02 p.m., R14's skin was warm and intact with no skin concerns. -on 11/25/24 at 4:26 p.m., R14 had no skin issues. -on 12/2/24 at 9:17 p.m., R14 had no skin issues. -on 12/9/24 at 10:28 p.m., R14 had no new skin issues. R14's care plan revised 11/29/24, lacked	21540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21540	Continued From page 10 indication R14 was prescribed an antibiotic. When interviewed on 12/10/24 at 12:53 p.m., R14 stated they had "tumor like" things on their groin area and that was why they were taking the clindamycin lotion. R14 verified they were still taking it daily. R14 further stated staff had been unable to get a refill and so she was working with her dermatologist. R14's dermatologist has said they would give 2 more refills but would not do any more until seen again. R14 stated once starting the clindamycin they were able to feel the little pockets under her skin but stated everything else cleared up "right away". R14 stated when she had trouble getting it refilled, she was using the lotion "every other day or so" so it would last. R14 stated during the time of taking it sparingly, her skin had no change. R14 stated the facility or provider had not talked about any risks of long-term antibiotic use. When interviewed on 2/10/24 at 2:22 p.m., registered nurse (RN)-B stated when residents on antibiotics required monitoring of symptoms and tracking to determine if they are improving. This was documented as a progress note. When a resident has a topical antibiotic, the nurse would then monitor the skin. RN-B was not aware R14 was on the clindamycin topical ointment but verified the order and noted there was no end date. RN-B was not aware of any skin altercations or infections for R14 and wasn't sure if the antibiotic lotion was needed. RN-B stated R14 used an outside provider and it was more difficult as R14 handled her own medications. When interviewed on 12/10/24 at 2:50 p.m., with the infection preventionist (IP) and the Director of Nursing (DON), the IP verified R14's antibiotic was not included in the facility's tracking for	21540			

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21540	Continued From page 11 antibiotic. IP stated this was not currently tracked and would need to investigate it further. When interviewed on 12/11/24 at 12:18 p.m., the Director of Nursing (DON) verified R14's dermatology note indicated the clindamycin lotion was to be used for a year and the order should have expired in 5/2024. DON was not sure R14 still required the medication and stated a risk and benefit was needed if she wanted it continued. R14 managed her medications and communications with the dermatologist and the DON stated collaboration was sometimes challenging. Furthermore, DON verified the antibiotic list the IP had been pulling from the electronic medical record was only oral antibiotics and had not included topical. DON expected all antibiotics to be tracked for residents in the facility. A facility policy titled Antibiotic Stewardship Policy 2024, directed the provider to ensure a duration was included in an antibiotic order. Furthermore, the policy directed the nurse to monitor and evaluation the effectiveness of the antibiotic and the residents response to the antibiotic to identify if the antibiotic was still indicated. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted on December 10, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Little Sisters of the Poor, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

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

Electronically Signed

TITLE

(X6) DATE

12/27/2024

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: This 5-story building constructed in 1976, addition in 1985 and both was determined to be of Type II(222) construction. It has a partial basement. the building has a full fire sprinklered throughout. The facility has a capacity of 73 beds and had a census of 45 at the time of the survey.	K 000			

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K 000 K 311 SS=F	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 12/10/2024, between 10:00 AM and 11:30 PM, observations and staff interview revealed that there was a ceiling tile missing in the laundry room. This condition would delay the activation of the fire alarm and sprinkler system in the event of an emergency. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 000 K 311	Preparation, submissions, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility does not agree with the alleged deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facilities allegation of compliance. It is the policy of Little Sisters of the Poor to ensure that all vertical openings are properly enclosed.	1/17/25	

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K 311	Continued From page 3	K 311			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 33.2.3.4.1, 9.6, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, 14.4.5, 14.4.5.3. These deficient findings could have a widespread impact on the residents within the facility.	K 345	1. Corrective action: The ceiling tile in question was immediately replaced 2. Systemic changes: An audit will be conducted to ensure that all ceiling tiles are replaced and all vertical openings are properly enclosed. 3. Monitoring process to ensure lasting solutions: Maintenance team has been instructed to ensure that ceiling tiles are replaced after completion of any work order and will be responsible to verify closures after work is completed by contractors. 4. Responsible Party: Director of Maintenance It is the policy of Little Sisters of the Poor to maintain and test the fire alarm system per NFPA 101. 1. Corrective action: The documentation could not be located during survey, but documents were retrieved to indicate that the sensitivity report and the annual fire alarm testing was completed in August,	1/17/25	

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K 345	Continued From page 4 Findings include: 1. On 12/10/2024 between 10:00 AM and 11:30AM, it was revealed during a review of available documentation that a detailed sensitivity report was not available for review. 2. On 12/10/2024 between 10:00 AM and 11:30AM, it was revealed during a review of available documentation that a annual fire alarm testing was not available for review. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 345	2024. 2. Systemic changes: Facility has retrieved the appropriate documentation and has filed it with the appropriate binder of documents. In the future, maintenance will be responsible to ensure that all documentation is immediately added to the appropriate binder. 3. Monitoring process to ensure lasting solutions: Maintenance Team has been instructed to ensure that all testing and reports are filed away in the appropriate binders so they are readily available for reviews. Sensitivity Reports and annual fire alarm testing will be shared with Quality Assurance Committee as completed. 4. Responsible Party: Director of Maintenance		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as	K 351		1/17/25	

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K 351	Continued From page 5 required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/10/2024 between 10:00 AM and 11:30AM, it was revealed by observation that there was items in contact with the sprinkler system above the ceiling in four locations on 3rd and 4th floors at the stairwells. This included wires and conduit. An interview with the Director of Maintance verified these deficient findings at the time of discovery.	K 351	It is the policy of the facility that sprinkler heads are installed per NFPA 101. 1. Corrective action: Regarding the locations cited, Maintenance immediately adjusted the areas in question to ensure that wires did not come into contact with the sprinkler piping. 2. Systemic changes: Given that the situation was noted on 3rd and 4th floor, Maintenance will review all sprinkler pipes on each of these floors to ensure that wires, conduit, or other items are not touching the sprinkler piping. Moreover, Maintenance staff will audit select areas on 1st and 2nd floor to ensure compliance and may do additional monitoring or review based upon this initial audit. 3. Monitoring process to ensure lasting solutions: Maintenance Staff will complete random audits monthly during the following three months and report all finding back to the Quality Assurance and Performance Improvement Team. Based upon results will determine if future audits may be needed. Maintenance Director will continue to inform vendors/contractors of these requirements. 4. Responsible Party: Director of Maintenance		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		1/17/25	

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K 353	Continued From page 6 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a widespread impact on the residents within the facility. Findings include: On 12/10/2024 between 10:00 AM and 11:30 AM, it was revealed by observation that storage			K 353	It is the policy of the facility to maintain spacing between storage and the sprinkler system per NFPA 101. 1. Corrective action: Regarding the two locations cited, which included the janitor closet and the electrical room, maintenance immediately removed those items. 2. Systemic changes: Maintenance and janitorial team members have been instructed to ensure that there is an 18-inch clearance to the sprinkler head. Maintenance will audit all janitorial closets and electrical rooms to ensure compliance. 3. Monitoring process to ensure lasting		

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K 353	Continued From page 7 materials had been placed within 18" of the sprinkler system inside room 483 and 484.. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	solutions: Maintenance team will conduct monthly random audits for 3 months to ensure compliance and report all findings to the Quality Assurance Committee. Based upon results, future audits may be conducted. 4. Responsible Party: Director of Maintenance	1/17/25	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This	K 362	It is the policy of the facility to maintain corridor walls per NFPA 101. 1. Corrective action: Regarding the one		

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K 362	Continued From page 8 deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/10/2024 between 10:00 and 11:30 AM, it was revealed by observation that there was a conduit penetrating the deck that had not been sealed in the 1 hour rated electrical room 389. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 362	conduit that penetrated the wall, maintenance staff immediately sealed and fire caulked the hole. 2. Systemic changes: Maintenance staff will be instructed to ensure that all corridor walls are sealed after work is performed to ensure a proper smoke barrier. Moreover, Maintenance staff will be responsible to review contracted work to ensure fire caulking is performed. 3. Monitoring process to ensure lasting solutions: Maintenance team will conduct monthly random audits for 3 months to ensure compliance and report all findings to the Quality Assurance Committee. Based upon outcome of these results will determine the need for future audits. Maintenance Director will continue to inform vendors/contractors of these requirements. 4. Responsible Party: Director of Maintenance		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363		1/17/25	

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NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363	Continued From page 9 requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5, NFPA 80, Standard for Fire Doors.. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 12/10/2024 between 10:00 AM and 11:30AM, it was revealed by observation that the 1 hour fire rated doors to the laundry room had a	K 363	It is the policy of the facility that vertical openings resist the passage of smoke. 1. Corrective action: Regarding the gap on the laundry door, the facility ordered the appropriate part for installation to resist the passage of smoke through that doorway. 2. Systemic changes: Maintenance staff have been instructed of this process and will audit all common area doorways and will address any gaps that are greater than 1/8".		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245524	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
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K 363	Continued From page 10 gap great than 1/8". An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 363	3. Monitoring process to ensure lasting solutions: Maintenance team will conduct monthly random audits for 3 months to ensure compliance and report all findings to the Quality Assurance Committee. Based upon outcome of these results will determine the need for future audits. 4. Responsible Party: Director of Maintenance	1/17/25	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 511	It is the policy of the facility to secure all electrical panels per NFPA 99. 1. Corrective action: Regarding the electrical panel in the loading dock that was not locked, maintenance is ordering the lock to ensure that panel is secured. 2. Systemic changes: Electrical panels will be reviewed to ensure that they all are properly locked. 3. Monitoring process to ensure lasting solutions: Maintenance team will conduct		

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K 511	Continued From page 11 On 12/10/2024, between 10:00 AM and 11:30 AM, it was revealed by observation that the electrical panel located in the loading dock was not locked. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	random monthly audits for 3 months to ensure compliance and report all findings to the Quality Assurance Committee. Based upon outcome of these results will determine the need for future audits. 4. Responsible Party: Director of Maintenance		