DEPARTMENT OF HEALTH

Protecting, Maintaining, and Improving the Health of All Minnesotans

Electronically Delivered Via Email

December 3, 2025

Administrator
407 EAST 4TH STREET
DULUTH, MN 55805

Re: Event ID: 1D96F1-H1

Dear Administrator:

A survey was completed at your agency by the Minnesota Department(s) of Health on December 3, 2025, for the purpose of assessing compliance with Federal certification regulations for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more deficiencies. The findings from this survey are documented on the electronically delivered form CMS 2567.

Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency.

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

A provider or supplier is expected to take the steps necessary to achieve compliance within 60 days of the exit interview. If possible, please type your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original to the following address within ten calendar days of your receipt of this notice.

Questions regarding your plan of correction should also be directed to the below contact.

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health

705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us

Office: (218) 308-2104

Please make a copy of your plan of correction for your records.

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten business days may result in decertification and a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action.

If, upon a revisit within forty-five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that your certification be terminated, effective 3/3/2026

Please feel free to call me with any questions related to this letter.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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Administrator

ESSENTIA HEALTH ST MARYS HOSPICE & PALLIATIVE CARE
407 EAST 4TH STREET
DULUTH, MN 55805

Re: Event ID: 1D96F1-H1

Dear Administrator:

On December 3, 2025, a survey was completed at your agency for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under MN Rule 4664.

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 feel free to contact me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 241521	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH ST MARYS HOSPICE & PALLIATIVE CARE	407 EAST 4TH STREET , DULUTH, Minnesota, 55805

(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
L0519	RIGHTS OF THE PATIENT CFR(s): 418.52(c)(8) [The patient has a right to the following:] (8) Receive information about the scope of services that the hospice will provide and specific limitations on those services. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the agency failed to inform patients about the scope of services the hospice would provide and limitations of those services for 1 of 3 patients (R1) reviewed for discharge processes. Findings include: P1's plan of care (POC) dated 10/8/25 for benefit period 10/22/25 to 1/19/26, identified a start of care (SOC) of 7/24/25. Diagnoses included decompensated hepatic cirrhosis, depression with anxiety, hepatic encephalopathy, ascites due to alcoholic cirrhosis and alcohol use disorder. Services were ordered for medical social work visits one to five visits every month for one month for social and emotional support needs, skilled nursing visits (SNV) one visit every week for twelve weeks to assist with nutrition, anxiety, pain, infection, and management of medications, and spiritual care visits two to twelve visits every twelve weeks for twelve weeks for grief and spiritual support. P1's medical record identified the following: -On 10/1/25, a care conference was held regarding substance use and compliance with hospice medications while living in an assisted living home. P1 was invited to attend, however did not attend. The assisted living staff indicated they would discuss their expectations of P1 while living at the facility. Hospice noted P1 called hospice regarding his concern of being kicked out of the assisted living and his desire to continue to reside at the facility. Hospice documented the agency had no determination over P1's behavior and could only offer supports. The medical record lacked	L0519	Rights of the patient 418.52(c)(8). Process leading to the deficiency: The patient who was discharged for cause was not told that a discharge for cause was being considered. The patient was not given clear information about the Procedure for Correction: All hospice staff were educated on 11/7/2025 by the Quality, Compliance, and Education Program Manager on the Discharge for Cause regulations, the patient rights requirements under 418.52 (c)(8), and the expectation that all patients be informed of the services hospice will provide and any limitations regarding the provision of services. Staff were also educated on the newly implemented "Hospice Risk Reduction Intervention" documentation. Staff were instructed that this documentation must be completed for any patient being considered for Discharge for Cause and must include clear documentation that the patient was informed of potential discharge and the reasons for it, including any limitations on the agency's ability to provide safe and effective care. Agency to update admission forms to include verbiage on scope/limitations of service, ensuring patients are aware of limitations at the time of admission.	11/7/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Operations Director	12/09/2025

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L0519	Continued from page 1 documentation the hospice agency notified P1 of limitation of their services if P1 had a lack of housing. -On 10/6/25, a SNV was made with various assessments. The visit note lacked any review of the 10/1/25 care conference with P1, including any limitations or discontinuation of hospice services if P1 was no longer able to reside at the assisted living. -On 10/9/25, the assisted living called the hospice agency to report behaviors and continued substance use. The hospice agency's decision was to immediately discharge P1 from hospice services due to P1 was homeless and the agency could not provide hospice services and controlled substances in an unstructured environment without oversight. The medical record lacked evidence P1 was informed of the limitations of hospice services on admission to hospice or during his episode of care. During interview on 10/21/25, at 2:30 p.m. registered nurse (RN)-A stated she had admitted P1 to the hospice agency when P1 was living at temporary housing for homeless people. P1 then transitioned to an assisted living. Hospice attended a care conference with the assisted living facility on 10/1/25, to discuss P1's drug use and behavior at the facility. P1 chose not to attend the care conference. During that meeting, the assisted living was not specific with what they would need to discharge P1 from the facility and they were willing to work with P1 and wanted to help him. No consequences or ultimatum were given to P1 regarding continued drug use in the assisted living facility. RN-A received a call from the assisted living that P1 had erratic behaviors, making other residents feel unsafe the evening of 10/8/25, and requested a skilled nurse visit to check on him. RN-A made the visit. The assisted living was going to call their supervisors, so RN-A left. Later RN-A received a call from the assisted living that P1 would not be able to stay there. RN-A contacted the hospice agency supervisors to decide what to do and was told to discharge P1 from hospice services. RN-A made a discharge visit on 10/9/25 and told P1 he could go to the homeless shelter and for pain, he was to go to the emergency room. During telephone interview on 10/21/25, at 3:30 p.m. the assisted living director (ALD)-A stated they had multiple conversations with hospice regarding P1's behaviors and illicit drug use. ALD-A asked hospice for help on 10/9/25, when P1 was acting so erratically and hospice pretty much said to do what we had to do. At no	L0519	Ongoing Monitoring Procedure: Any hospice patient being considered for Discharge for Cause from the hospice program will require an IDG meeting to ensure all regulations are followed and that the patient has been fulling informed of the scope of services and limitations. All potential Discharge for Cause cases will be audited by the Quality, Compliance, and Education Program Manager or designee for 90 days to ensure documentation meets regulatory requirements. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on results. Who is responsible: Quality, Compliance, and Education Program Manager or designee.	

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L0519	Continued from page 2 time was it ever discussed hospice was going to discharge P1. During interview on 10/22/25, at 9:00 a.m. RN-A stated to attempt to do daily medication administration for P1 would have put the agency in the position of having to pick up medications and potentially destroy medications if P1 did not show up for daily administration and the agency would not have any place to store medications. P1 would not have been a candidate to reside in the agency hospice house as certain criteria needed to be met and P1 did not meet the criteria. P1's hospice physician was updated regularly on his behavior and illicit drug use. When interviewed on 10/22/25, at 12:30 p.m. the hospice medical director (MD)-A stated she had been aware a care conference had been held on 10/1/25 to discuss P1's behavior at the assisted living where he resided. The assisted living facility was the only place willing to take P1 so P1 had no other options if he was evicted and the hospice team was very concerned about that. The hospice team was aware of P1's drug use and behaviors prior to 10/9/25. The hospice agency should have been more on point with P1 regarding the consequences of his behaviors. The agency had to discharge P1 due to his escalating behaviors and staff concerns. The agency could have made it safer for P1 and gave him better options. The agency felt they had to discharge P1 from hospice because the assisted living was going away and the ability to see P1 in a safe setting would be gone. Thinking more about the hospice program and staff safety. The hospice policy Discharge for Cause dated 2/22/24, identified discharge for cause should be the last option for a hospice provider. There should be documented evidence of provider attempts to solve the issue that le to the discharge for cause. The hospice RN or social worker should advise the patient that a discharge for cause was being considered. The hospice interdisciplinary team (IDT) should make a serious effort to resolve the problem/behaviors presented by the patient in the patient's home. The agency's undated Live Discharge Hospice Checklist directed staff to discuss pending discharges with the hospice team at their IDT and with the patient's caregivers and the patient's attending physician. Staff were directed to have the patient or caregiver sign the Medicare Notice of Non-Coverage form at least 10 days prior to discharge. Staff were to document all attempts to contact family to discuss discharge. UPDATE OF COMPREHENSIVE ASSESSMENT	L0519		
L0533		L0533		

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L0533	Continued from page 3 CFR(s): 418.54(d) The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. This STANDARD is NOT MET as evidenced by: Based on interview and document review the agency failed to update the comprehensive assessment and plan of care to reflect changes in patient progress and goals that had occurred since initial admission assessments for 1 of 3 patients (P1) reviewed for discharge. Findings include: P1's plan of care (POC) dated 10/8/25 for benefit period 10/22/25 to 1/19/26, identified a start of care (SOC) of 7/24/25. Diagnoses included decompensated hepatic cirrhosis, depression with anxiety, hepatic encephalopathy, ascites due to alcoholic cirrhosis and alcohol use disorder. Services were ordered for medical social work visits one to five visits every month for one month for social and emotional support needs, skilled nursing visits (SNV) one visit every week for twelve weeks to assist with nutrition, anxiety, pain, infection, and management of medications, and spiritual care visits two to twelve visits every twelve weeks for twelve weeks for grief and spiritual support. P1's medical record identified the following:On 8/25/25, a social work (SW) note dated 8/25/25, identified the housing staff where P1 resided, reported P1 was disruptive in the house and there was suspicion of methamphetamine use. The housing agency notified SW-A P1 would need to find other housing.On 8/27/25, P1's POC identified a problem for future care placement with the SW plan to assist P1 in applying for medical assistance for long term care placement and assistance to coordinate a search for home or placement at an assisted living or skilled nursing facility with start date 7/24/25. The POC lacked identification and approaches for P1's inappropriate behaviors. The POC lacked an assessment of P1's behavior or documentation	L0533	Update of Comprehensive Assessment 418.54(d) Process leading to the deficiency: The patient's comprehensive assessment and plan of care were not updated to show the changes in the patient's behavior or the interventions that were put into place. Drug paraphernalia was found in the patient's room, but the assessment and the plan of care were not revised to reflect this concern or to guide hospice and facility staff on needed safety interventions. Because the documentation was not updated, the care plan did not match the patient's current needs or risks. SW-E-173444 HPC-Initial, Comprehensive and Ongoing Assessments was not followed. Procedure for Correction: The hospice team received education from the Quality, Compliance, and Program Manager on 11/7/2025 regarding the requirements of CFR 418.54 (d), including the need to update the comprehensive assessment and plan of care whenever the patient's condition changes and at least every 15 days. Educations also covered the new process for patients who may be considered for Discharge for Cause. The Team was educated on the new Hospice Risk Reduction Intervention documentation, which must be completed for any patient being considered for Discharge for Cause.	11/07/2025

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L0533	Continued from page 4 the hospice's interdisciplinary team (IDT) were aware of P1's behavior or had discussed implications of the behaviors to the hospice POC and treatment goals. On 9/30/25, a note identified assisted living staff reported P1 was found smoking a drug pipe in his room under his covers. A skilled nurse visit (SNV) was completed. Registered nurse (RN)-A observed a glass pipe lying on floor of P1's room. P1 was sleepy and minimally responsive. The assisted living staff reported frustration over P1's behavior.On 10/1/25, a note identified a care conference was held regarding inappropriate behavior, suspected substance uses and compliance with hospice medications while living in an assisted living home. P1 was invited to attend, however declined the invitation. The assisted living planned to talk with P1 to discuss their expectations of P1 while living at the facility. Hospice noted P1 had called hospice regarding his concern of being kicked out of the assisted living and his desire to continue to reside at the facility. Hospice documented the agency had no determination over P1's behavior and could only offer supports. P1's POC dated 10/8/25, lacked documentation of the above concerns or new interventions or approaches to address these concerns. 10/8/25, lacked any assessment of inappropriate behaviors, illicit drug use with potential interactions with hospice medications and treatments. The POC also lacked approaches and goals related to P1's suspected illicit drug use, disruptive behaviors, and potential of eviction from his home related to his actions and behaviors. In addition, the POC failed to identify a plan to address P1's lack of housing if he should be evicted from the assisted living, he currently resided in. During interview on 10/21/25 at 2:35 p.m. registered nurse (RN)-A stated she did remember a glass pipe on the floor of P1's room at the assisted living during one of her skilled nurse visits (SNV). The facility requested a care conference on 10/1/25, to discuss P1's drug use. P1 refused to attend and went to stay with his significant other as he was worried, he would be evicted from the assisted living. The assisted living was willing to try and work with P1, however, no consequences or plan was developed if P1 continued drug use. RN-A was aware P1 was using illicit drugs but felt like as a hospice that was not something hospice assessed as that was more on the assisted living to deal with. RN-A stated hospice was there more as a support and could not control what happened at the assisted living. RN-A stated it was hard to have a coherent discussion with P1 due to his erratic behaviors. RN-A was not sure if was related to his drug use or elevated ammonia levels. Whenever there was any drug abuse or things like that, RN-A called her supervisor as well as several conversations with the	L0533	Procedure for Correction Continued: Staff were educated that they must document: the behaviors or factors increasing risk to the patient and or hospice staff to provide care safely and effectively, that Discharge for Cause is being considered, the interventions discussed to reduce safety risks, which care providers participated in the discussion, whether the patient agreed to the interventions, that the IDT was updated, and the scheduled return visit to reassess the interventions and appropriateness of ongoing care. Staff were educated that the plan of care and comprehensive assessment must be updated whenever new interventions are put into place. Ongoing Monitoring Procedure: Any hospice patient being considered for Discharge for Cause from the hospice program will require an IDG meeting to ensure all regulations are followed and that comprehensive assessments and plans of care are updated. All potential Discharge for Cause cases will be audited by the Quality, Compliance, and Education Program Manager or designee for 90 days to ensure compliance. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on results. Who is responsible: Quality, Compliance, and Education Program Manager or designee.	11/07/2025

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L0533	Continued from page 5 hospice physician. The assisted living did a full assessment of P1 and accepted him and the hospice social worker was also working with the community mental health worker. During telephone interview on 10/21/25, at 4:12 p.m. the social worker (SW)-A stated she had assisted P1 to find a place to live and the assisted living had accepted him and so he moved over there. There were challenges during P1's time at the assisted living. SW-A would get updated and follow up when needed. At one point, the facility held a care conference. They were very frustrated at that point and so we all met together to talk it through. The assisted living stated they would follow up with P1 about his drug use and behavior, and if he turned in all his drugs and paraphernalia he would be allowed to stay there. Hospice medications were discussed, and the use of illicit drugs would not be good, but the assisted living facility was responsible to manage his drug use and behavior, not hospice. The hospice agency was just there as a support. The agency was dependent on what the assisted living decided but had discussed if P1 was evicted, hospice would have to discharge him. If P1 did not have housing, it would be a huge problem to have the hospice medications on the street. So, the agency discharge was dependent on the assisted living discharge. The agency would not have discharged P1 if the assisted living had kept him there. During interview on 10/22/25, at 12:30 p.m. the hospice physician (MD)-A stated she was aware a care conference had been held with the assisted living to discuss P1's behaviors and drug use. P1 had no other housing options and that concerned the hospice staff. P1's drug and alcohol use would affect hospice medications and treatment. The agency's policy Initial, Comprehensive and Ongoing Assessments dated 8/28/24, identified an update of the comprehensive assessment must be accomplished by the hospice interdisciplinary team (IDT) and must consider changes that had taken place since the initial assessment. It must include information on the patent's progress toward desired outcomes and well as a re-assessment of the patient's response to care. Reassessments may include physiological response to care and service, changes in condition, diagnosis, prognosis, changes in patient's care environment or support systems, psychosocial patient needs, spiritual needs and safety/home environment. Based on the re-assessments, the plan of care, including problems, needs, goals, and outcomes would be reviewed and revised.	L0533		

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L0533 L0678	CONTENT CFR(s): 418.104(a)(7) [Each patient's record must include the following:] (7) Physician orders. This STANDARD is NOT MET as evidenced by: Based on interview and document review, the agency failed to obtained physician order to discharge from hospice services for 1 of 3 patients (P1) reviewed for discharge. Findings include: P1's plan of care (POC) dated 10/8/25 for benefit period 10/22/25 to 1/19/26, identified a start of care (SOC) of 7/24/25. Diagnoses included decompensated hepatic cirrhosis, depression with anxiety, hepatic encephalopathy, ascites due to alcoholic cirrhosis and alcohol use disorder. Services were ordered for medical social work visits one to five visits every month for one month for social and emotional support needs, skilled nursing visits (SNV) one visit every week for twelve weeks to assist with nutrition, anxiety, pain, infection, and management of medications, and spiritual care visits two to twelve visits every twelve weeks for twelve weeks for grief and spiritual support. P1's medical record identified the following: -On 10/9/25, the assisted living called hospice agency to report behaviors and continued substance use. The hospice agency's decision was to discharge P1 from hospice services due to P1 was homeless and the agency could not provide hospice services and controlled substances in an unstructured environment without oversight. The medical record lacked evidence physician orders for discharging P1 from hospice was obtained, along with medication orders. During interview on 10/21/25, at 2:35 p.m. registered nurse (RN)-A stated she had discharged P1 for cause on 10/9/25. RN-A stated she did not know if the assisted living had given P1 his routine medications, but she instructed them not to send his controlled substance medications with him. RN-A notified the pharmacy that P1 had been discharged from hospice. RN-A stated she just assumed an order had been placed to cover the discharge as it was discussed in multiple meetings with	L0533 L0678	Physician Orders 418.104(a)(7) Process leading to the deficiency: The RN received a verbal order from the hospice physician to discharge the patient, which followed our hospice workflow that states the RN should obtain a discharge order from the Hospice Medical Director. The RN completed the discharge steps but did not send the verbal order to the physician for signature in the electronic medical record. Because the order was never signed and placed in the electronic medical record, the patient's chart did not contain the required discharge order. Procedure for Correction: The entire hospice team was educated on 11/7/2025 about the discharge for cause CoPs, regulations, and the updated discharge process for the home hospice program. Education included review of CFR 418.104(a)(7), which requires that each hospice patient must have a physician order before being discharged. Hospice staff were educated that a written discharge order from the hospice medical director is required for every discharge and must be present in the medical record. Hospice RNs will now be required to document in the discharge note that a written discharge order was obtained from the hospice medical director. This will be a mandatory part of the discharge workflow.	11/07/2025

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ESSENTIA HEALTH ST MARYS HOSPICE & PALLIATIVE CARE	407 EAST 4TH STREET , DULUTH, Minnesota, 55805

(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
L0678	Continued from page 7 the physician throughout the day. RN-A had done all her discharge paperwork and documentations; however, the hospice physician had not documented any discharge orders in the medical record. When interviewed on 10/22/25, at 12:30 p.m. the hospice physician (MD)-A stated she had not completed a discharge statement at the time of P1's discharge and had just completed it yesterday 10/21/25, after survey entrance. The agency did not normally do a discharge statement when a client was discharged for cause, but she did complete one yesterday for clarification. Normally MD-A would get the discharge orders from the nurse to sign and then MD-A put a note in the medical record as a summary. During interview on 10/22/25, at 2:30 p.m. program manager (PM)-A stated P1 did not have a formal discharge order in his chart. The agency's normal practice was to complete a discharge order for the hospice physician to sign as part of the client's medical record. The discharging nurse was in communication with MD-A and had received orders ok to discharge from hospice services, however, had not formally documented the orders in P1's medical record as she should have done. The agency's policy Patient No Longer Terminally Ill Live Discharge dated 3/26/25, identified the hospice physician would sign a discharge order, notify the attending physician of the plan for discharge and write a progress note documenting the reason for discharge.	L0678	Ongoing Monitoring Procedure: All live discharge documentation will be audited for 90 days by the Quality, Compliance, and Education Program Manager or designee to ensure the required physician order is present and correctly documented. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. Who is responsible: Quality, Compliance, and Education Program Manager or designee.	
L0000	INITIAL COMMENTS On 10/20/25 to 10/22/25 and an abbreviated survey was conducted. This resulted in a standard survey at Essentia Health St Mary's Hospice and Palliative Care. The agency was found to have not met the requirements at 42 CFR. Part §418 for Hospice Agencies. The following complaints were reviewed: H15215852C (2641212).	L0000	Received 12/9/25 Reviewed and approved 12/16/25 Jennifer Bahr Digitally signed by Jennifer Bahr Date: 2025.12.16 14:40:57 -06'00'	