



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
September 12, 2023

Administrator  
Providence Place  
3720 23rd Avenue South  
Minneapolis, MN 55407

RE: CCN: 245271  
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 18, 2023, we notified you a remedy was imposed. On August 31, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 25, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 2, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 18, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 2, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 25, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

*An equal opportunity employer.*



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August 18, 2023

Administrator  
Providence Place  
3720 23rd Avenue South  
Minneapolis, MN 55407

RE: CCN: 245271  
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 3, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

## **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 2, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

Providence Place

August 18, 2023

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- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

### **NURSE AIDE TRAINING PROHIBITION**

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 2, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Providence Place will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 2, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

### **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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

Providence Place

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- An electronic acknowledgement signature and date by an official facility representative.

## **DEPARTMENT CONTACT**

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

**Annette Winters, Rapid Response Unit Supervisor**

**Metro 1, Golden Rule Office**

**Licensing and Certification Program**

**Health Regulation Division**

**Minnesota Department of Health**

**85 East Seventh Place, Suite 220**

**P.O. Box 64900**

**Saint Paul, Minnesota 55164-0900**

**Email: [annette.m.winters@state.mn.us](mailto:annette.m.winters@state.mn.us)**

**Mobile: (651) 558-7558**

## **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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

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and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

## **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

**[Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov)**

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov).

## **INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)**

In accordance with 42 CFR 488.331, 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:

Providence Place  
August 18, 2023  
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Nursing Home Informal Dispute Process  
Minnesota Department of Health  
Health Regulation Division  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: [https://mdhprovidercontent.web.health.state.mn.us/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



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August 18, 2023

Administrator  
Providence Place  
3720 23rd Avenue South  
Minneapolis, MN 55407

Re: Event ID: OTX511

Dear Administrator:

The above facility survey was completed on August 3, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing 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.

Electronically posted 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 call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

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

PRINTED: 08/24/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245271</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/03/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PROVIDENCE PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3720 23RD AVENUE SOUTH</b> <b>MINNEAPOLIS, MN 55407</b>
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(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 000	<p>INITIAL COMMENTS</p> <p>On 8/1/23 through 8/3/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed. H52713802C(MN95347).</p> <p>The following complaints were reviewed. H52714036C(MN95553) with a deficiency issued at F740.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 740 SS=G	<p>Behavioral Health Services CFR(s): 483.40</p> <p>§483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not</p>	F 740		8/25/23

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

TITLE

(X6) DATE

Electronically Signed

08/22/2023

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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F 740	<p>Continued From page 1</p> <p>limited to, the prevention and treatment of mental and substance use disorders.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, and document review, the facility failed to coordinate care with psychiatric providers, care plan and identify symptoms of psychosis, and obtain a monthly complete blood count (CBC) to identify the neutrophil level required before the pharmacy would dispense antipsychotic medication for 1 of 3 residents (R1) who had schizophrenia. This failure resulted in harm, when R1 abruptly missed nine doses of an antipsychotic medication, leading to worsening psychotic symptoms, resulting in hospitalization.</p> <p>Findings Include:</p> <p>R1's hospital discharge note dated 1/4/23, indicated he had paranoid schizophrenia. He was taking Clozaril (an antipsychotic medication for the management of severely ill schizophrenic patients who fail to respond adequately to standard drug treatment for schizophrenia) 100 mg once a day. His schizophrenia base line included his mood and signs and symptoms of psychosis (paranoia, disorganized thoughts, decline in self-care and hygiene, poor sleep, confused speech, and unable to determine reality and fantasy.)</p> <p>R1's admission record indicated R1 had two care providers: a primary care physician and a nurse practitioner. The admission record did not include R1's psychiatrists (P)-A or P-B as care providers.</p> <p>R1's medical order dated 4/28/23 at 3:00 p.m., indicated he was taking an antipsychotic medication Clozaril 200 mg at bedtime for</p>	F 740	<p>F740:</p> <p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:</p> <ol style="list-style-type: none"> <li>1. R1 remains at the hospital currently.</li> <li>2. An internal audit was completed identifying all residents that currently receive Clozaril.</li> <li>3. All residents that are currently receiving Clozaril had orders reviewed to ensure appropriate diagnosis was in place as well as the appropriate Target Behaviors. All residents receiving Clozaril were audited to ensure medication and labs are monitored by an outside agency that is familiar with the process. All face sheets of identified residents were reviewed to ensure psych/mental health services were identified with phone numbers in place. Nursing Management Team educated on Clozaril orders, diagnosis, target behaviors, lab monitoring, and outside monitoring</li> </ol>	

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F 740	<p>Continued From page 2</p> <p>schizoaffective disorder and bipolar (when the resident had either hypermania or depression) and a description for medication monitoring for side effects associated with Clozaril.</p> <p>R1's care plan dated 5/1/23, indicated he used the antipsychotic medication Clozaril. The care plan directed the nursing staff to give the medication according to the medical provider's instructions and to monitor for potential side effects. In addition, the nursing staff would instruct R1 about the risks and benefits associated with long-term use of Clozaril. The care plan described specific side effects associated with Clozaril use but did not include care planned interventions for R1's signs and symptoms of a worsening psychosis.</p> <p>R1's facility's nurse practitioner (FNP)-A specialized in the care for nursing home residents order dated 5/3/23, indicated R1 needed a blood test to monitor his neutrophil levels every month. One side effect associated with long-term Clozaril use is a significant loss of neutrophil levels leaving him unable to fight off infections.</p> <p>R1's admission Minimum Data Set (MDS) dated 5/4/23, indicated R1 had intact cognition, mild depression and delusions caused by his schizoaffective (schizophrenia symptoms to include depression or manic behavior) disorder. He did not have any hallucinations or delusions at the time of the evaluation. In addition, he had extensive heart and lung disease. R1 was able to move in bed, walk, and transfer himself independently. He did require supervision from one staff member to get dressed, use the toilet, and for all hygiene tasks.</p>	F 740	<p>services.</p> <p>4. All new residents will have orders audited x 1 month than randomly x 1 month to ensure that if they are on Clozaril the diagnosis is in place, correct and appropriate. Target Behaviors will be monitored for appropriateness. Nursing will ensure an outside source is in place to monitor the medication and labs. Face sheets will be updated to include psych/mental health provider and phone number. Care Plans will also be updated to reflect the above.</p> <p>5. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations.</p>	

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F 740	<p>Continued From page 3</p> <p>Facility's laboratory calendar book dated 5/4/23, indicated R1 needed a blood test to check his neutrophil level.</p> <p>R1's facility medical doctor (FDR)-A who specialized in the care for nursing home residents visit note dated 5/9/23, indicated R1's diagnosis was schizoaffective disorder with cognitive deficits. R1 had an extensive mental illness with hospitalizations, and was currently taking Clozaril. FDR indicated R1 had repetitive disjointed responses to questioning and was unable to provide any coherent history. FDR-A documented the need for psychiatry involvement and continued clozaril with pharmacy monitoring of CBC's.</p> <p>R1's consultant pharmacist (PH)-A's medication review dated 5/9/23, indicated R1 was on Clozaril and suggested the nursing staff should add target behavior monitoring (target behavior monitoring is done for early identification when a residents previously controlled psychosis symptoms are re-emerging, and would require a psychiatrist to reevaluate his schizophrenia condition. The target behaviors are specific and individualized to the resident's psychosis history when he first went on Clozaril or the last time the dose was decreased.)</p> <p>R1's medical order dated 5/15/23 at 3:00 p.m., indicated his target behavior was for verbal/physical aggression. Nursing staff were directed to implement non-medication interventions such as re-directing him to an activity he enjoyed such as watching T.V. and offering aroma therapy to calm down. Target behaviors did not include R1's schizophrenia base line to include his mood, and signs and symptoms of psychosis (paranoia, disorganized</p>	F 740		

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F 740	<p>Continued From page 4</p> <p>thoughts, decline in self-care and hygiene, poor sleep, confused speech, and unable to determine reality and fantasy.)</p> <p>R1's June MAR dated 6/1/23 through 6/30/23, indicated the facility followed medication orders. There was no indication the facility was monitoring for signs and symptoms of worsening psychosis.</p> <p>R1's social service note dated 6/9/23 at 6:28 p.m., indicated the facility's social worker (SW) received a phone call from R1's mental health case manager (MHCM)-A. MHCM-A wanted to alert the facility R1's psychiatric history included "paranoid behaviors and will accuse staff or others of stealing money that he never had, delusions that someone beat him up or punched him and delusions that he is often attack by people or objects."</p> <p>R1's progress note dated 6/13/23 at 5:47 p.m., indicated his cognition was intact, he did not have any acute changes to his mental status or signs of disorganized thoughts.</p> <p>R1's laboratory requisition form dated 6/28/23, indicated the only test he need was a thyroid test.</p> <p>Facility laboratory calendar book dated 6/29/23, indicated R1 needed a blood test to check his neutrophil. A note was added to the calendar indicating R1 refused to lab draw on 6/29/23, and it was rescheduled for another day.</p> <p>R1's July medication administration record dated 7/1/23 through 7/31/23, indicated a neutrophil test was required on 7/27/23, but the box for staff to document if it was done was left blank. Staff</p>	F 740		

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F 740	<p>Continued From page 5</p> <p>documented R1 received Clozaril every night until the nine days between 7/17/23 through 7/25/23, because the facility did not have the medication to give. R1's monthly orthostatic blood pressure was completed on 7/2/23. Lastly, the nursing staff on all shifts from 7/1/23 through 7/26/23, document no target behaviors of verbal or physical aggression. There was no indication the facility was monitoring for signs and symptoms of a worsening psychosis.</p> <p>R1's provider note dated 7/17/23, indicated the facility's nurse practitioner (FNP)-B who specialized in the care for nursing home residents visited him at the nursing home. Psychiatrist (P)-A was identified as his long-time psychiatrist.</p> <p>Facility laboratory calendar book dated 7/19/23, indicated R1 need his Valproic acid level and a liver panel (test of all the different liver components) and to add a neutrophil test.</p> <p>R1's laboratory request form dated 7/19/23, indicated R1 need his Valproic acid level and a liver panel. The box for a neutrophil level was blank.</p> <p>R1's progress note dated 7/19/23 at 8:00 a.m., indicated he refused the laboratory staff to draw his ordered blood tests. He stated, "No I am not having my labs drawn it's not necessary." Staff told him the doctor wanted him to have the test results, but he still refused. Staff updated the facility's nurse practitioner.</p> <p>R1's SW note dated 7/20/23 at 4:57 p.m., indicated MHCM-A was called and updated regarding R1 refused the laboratory to draw his blood work. MHCM-A stated she noticed an</p>	F 740		

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F 740	<p>Continued From page 6</p> <p>"increase in behaviors and paranoia" and frequent urination during her visit on 7/19/23. The SW documented she notified R1's nurse about the new behaviors and symptoms.</p> <p>R1's progress note dated 7/24/23 at 11:42 a.m., indicated licensed practical nurse (LPN)-A contacted the facility's medical providers regarding the laboratory order for a Valproic and Hepatic blood test.</p> <p>R1's progress note on 7/24/23 at 2:14 p.m., indicated he refused his weekly bath.</p> <p>R1's SW note dated 7/25/23 at 3:43 p.m., indicated she called MHCM-A regarding his "increased paranoia, obsessive behaviors and verbal aggression when redirected." MHCM-A instructed the facility to send him to the hospital for an evaluation.</p> <p>R1's FNP-A's order dated 7/25/23, indicated it was okay for the facility to transfer R1 to the hospital emergency room for a psychological evaluation.</p> <p>R1's medical record did not identify coordination of care with R1's psychiatrist pertaining to R1's behavioral health care needs related to antipsychotic medications and labs, and schizophrenia/schizo-affective behavior needs for level of functioning to identify appropriate goals and interventions.</p> <p>R1's psychiatry emergency room note on 7/25/23 at 5.23 p.m., identified MHCM-A told the receiving nurse over the past few weeks he started to "decompensate." R1 developed increased paranoia regarding the staff trying to poison him.</p>	F 740		

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F 740	<p>Continued From page 7</p> <p>He was neglecting his hygiene needs, using "racial slurs," and swearing. MHCM-A stated at baseline he has some degree of delusions, but the racial slurs and swearing were not. She also informed the receiving nurse he had been taking his Clozaril. R1 told the hospital staff the facility was not giving him his Clozaril. During the visit, the facility was contacted for information. The facility nurse stated he had increased paranoia, refused the lab to draw his blood work, refused food for the past three to four days and refused his medication.</p> <p>R1's progress note dated 7/25/23 at 6:19 p.m., indicated R1 was able to eat and was given Tylenol for pain. The hospital planned to send R1 back to the facility for continuation of care.</p> <p>R1's progress note dated 7/25/23 at 11:23 p.m., indicated he returned from the hospital and was observed almost falling out of his chair. He was assisted to his room and into bed where he slept without further concerns from the staff.</p> <p>R1's psychiatric registered nurse (RN)-A's progress note dated 7/25/23 at 8:42 a.m., indicated she received a phone call from MHCM-A regarding R1's emergency department visit on 7/25/23. MHCM-A was upset about the care R1 received at psychiatry emergency room regarding his paranoia and delusions. MHCM-A stated she was getting calls every day from the from the nursing home. MHDM-A told RN-A she was worried the facility would "kick" him out. In addition, R1 was "swearing and using the N word." She was worried about R1 wetting his pants and did not know if the emergency room checked for a urinary tract infection. RN-A told her psychiatrist (P)-A was out of the office until</p>	F 740		

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F 740	<p>Continued From page 8 7/31/23.</p> <p>R1's progress note dated 7/26/23 at 8:22 a.m., indicated licensed practical nurse (LPN)-A called the pharmacy to request a Clozaril refill but lab work was required before they would send a refill. She updated the facility's primary care provider.</p> <p>R1's note from RN-A dated 7/26/23 at 9:04 a.m., indicated she spoke with psychiatry emergency room, and they told her they "dropped the ball" when they did not collect a urine sample during his 7/25/23 visit. While he was there his pants were wet with urine and he refused to change his pants. He called the staff the "N" word and would not eat. MHCM-A stated she would take him back today for a reevaluation.</p> <p>R1's psychiatry's office telephone message note from LPN-A dated 7/26/23, at 9:45 a.m., indicated she wanted to speak to P-A's nurse to discuss his medication.</p> <p>R1's progress note dated 7/26/23 at 10:00 a.m. indicated LPN-A notified MHCM-A, the facility NP, and the psychiatry emergency room regarding his Clozaril.</p> <p>R1's psychiatric nurse RN-B note dated 7/26/23 at 10:04 a.m., indicated LPN-A reported R1 did not receive his Clozaril medication since 7/17/23, "as they forgot to order the labs." During the hospital admission on 7/25/23, R1 allowed the laboratory department to draw a neutrophil level and the results were sent to the facility. Since R1 was off Clozaril for longer than 48 hours he would need a new Clozaril order for a lower dose to be increased over time until he reached the previous 200 milligram (mg) dosage.</p>	F 740		

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F 740	<p>Continued From page 9</p> <p>R1's progress note dated 7/26/23 at 10:30 a.m., indicated he needed a hospital evaluation.</p> <p>R1's telephone order from psychiatrist (P)-B dated 7/26/23, at 10:38 a.m., indicated a new order for Clozaril. He would receive 50 mg on 7/26/23, and then 100 mg for two nights and 150 mg for two nights before resuming his 200 mg dosage.</p> <p>R1's progress note dated 7/26/23 at 10:45 a.m., indicated he developed a "babbling" nonsensical speech, and he was unable to hold himself up in bed. The facility NP evaluated him and directed the staff to send him to the emergency room for an evaluation.</p> <p>R1's emergency room documentation dated 7/26/23, indicated he was refusing his medication for a week and currently had an oxygen (O2) level of 85 percent (a normal level would be between 95 to 100 percent). MHCM-A told them she was worried about his recent change in mental status. He did not receive his Clozaril for one week and had refused his labs. R1's mental status at baseline was "slightly" delusional and normally pleasant. His physical exam indicated he was no longer oriented to his identity, the events leading up to his hospitalization, or where he was. His confusion indicated his previous stable schizophrenia and psychosis symptoms had deteriorated related to not taking his medication. The delirium (a mental state decline causing confusion, disorientation, and unable to think or remember clearly) was caused by the pneumonia and a deteriorated mental illness.</p> <p>R1's medical order dated 7/26/23, indicated the</p>	F 740		

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F 740	<p>Continued From page 10</p> <p>director of nursing (DON) wrote an order to stop the current neutrophil level every month. The new order directed the nursing staff to get a neutrophil level on 8/22/23 and continue collection every four weeks. In addition, nursing staff would fax the neutrophil test results to the pharmacy when available on 8/22/23 or 8/23/23, and then every four weeks.</p> <p>R1's email from PH-B dated 7/26/23 at 1:12 p.m., to the DON indicated R1 did not receive his Clozaril because his neutrophil level was not done in time. PH-B indicated Risk for Evaluation and Mitigation Strategy (REMS) safety program required by the Food and Drug Administration (FDA) required a current neutrophil level every month prior to dispensing a Clozaril refill.</p> <p>Facility's laboratory calendar book dated 7/27/23, indicated R1 needed a blood test to check his neutrophil level.</p> <p>R1's laboratory requisition form dated 7/27/23, for a neutrophil level. The requisition form was later faxed again to the laboratory to indicate it no longer need to be drawn.</p> <p>R1's nursing assistant (NA) task worksheet revised on 8/1/23, instructed the staff if he showed any aggressive behaviors to find a different caregiver to reapproach.</p> <p>During an interview on 8/1/23 at 3:41 p.m., MHCM-A stated she had worked with R1 for 15 years managing his care. He originally came to the facility related to falls and unable to care for himself. She said anytime the facility called her about R1's behavior or refusals she would go to the facility and address the issues with R1. After</p>	F 740		

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F 740	<p>Continued From page 11</p> <p>talking with him he was easy to redirect. R1 was on Clozaril since he was 20 years old around 1976. During the past two years he consistently took his medication. The Clozaril had stabilize his psychosis symptoms. She stated schizophrenia and symptoms of psychosis are more than verbal or behavioral aggression. The weeks prior to his hospitalization on 7/25/23, she noticed increased agitation, unable to redirect and he was very irritable. The facility told her on 7/25/23, R1 refused to eat because the staff were poisoning him. She instructed the facility to send him to the hospital for an evaluation on 7/25/23. She was upset with the hospital staff because they did not collect a urine sample to see if his frequent urination was the result of an infection. The next day when she visited R1 at the facility she found him speaking gibberish and unable to hold himself up in bed. She instructed the facility to send him back to the hospital for an evaluation. He was diagnosed with pneumonia leading to a heart attack and psychotic deterioration. R1 knows when he gets his Clozaril and today when she visited him in the hospital he kept saying "where is my Clozaril." When R1 takes is Clozaril "he is so nice and kind."</p> <p>During an interview on 8/1/23 at 12:00 p.m., the director of nursing (DON) stated she reviewed the events associated when R1 did not receive his Clozaril for nine days. She stated the facility held his Clozaril because he refused to complete the required neutrophil test to obtain more doses. On 7/25/23, when R1 was sent to the hospital she asked the staff to draw a neutrophil level because he had been refusing to get it at the facility. R1's blood work was completed, and she received an order to resume the Clozaril with a titrated (slowly increase the dosage in lesser amounts over days</p>	F 740		

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F 740	<p>Continued From page 12 until the original dose is reached) dose.</p> <p>During an interview on 8/1/23 at 12:32 p.m., registered nurse (RN)-C stated R1 was admitted to the cardiology floor because he had altered mental status related to not taking his Clozaril. Currently, his cardiac condition had resolved, but he remained on the unit until an inpatient psychiatric bed was available. At this time, his psychosis behaviors had resolved.</p> <p>During an interview on 8/1/23 at 2:50 p.m., the DON stated the reason for target behaviors was for early detection when his psychotic symptoms were no longer being managed by his antipsychotic medication. The target behaviors would include any symptom he had when he first started taking Clozaril. She did a thorough record review and found he was put on Clozaril for verbal and physical aggression. Once she identified the target behaviors, she added personalized interventions for the staff to use on the NA task sheet. She provided the Psychoactive Medication Guide she used when managing resident's antipsychotic medication. She reviewed the key elements required when developing a target behavior. She stated she did not know examples of psychosis symptoms but was sure verbal and behavioral aggression was acceptable. She explained the staff did not document any target behaviors between 7/17/23 through 7/25/23 because he was not aggressive even though the facility staff documented he stopped eating because the food was poisoned, and he had worsening behaviors, delusions, and paranoia. The lack of documented physical or behavioral aggression led her to believe R1's worsening symptoms were the result of a medical condition such as a urinary tract infection (UTI).</p>	F 740		

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F 740	<p>Continued From page 13</p> <p>She spoke with MHCM-A who was also concerned during the same time frame R1 might have a UTI because he had increased incidents of urinating on his clothes. During her investigation regarding the missing Clozaril doses, she completed audits for the other five residents receiving the same medication. She found their care plans were lacking documentation regarding specific target behaviors.</p> <p>During an interview on 8/2/23 at 9:15 a.m., the DON stated R1 refused to get his blood work drawn on 7/19/23. She stated they "kept trying" to get the neutrophil level drawn. She updated MHCM-A on 7/19/23, about the missing lab work, and they both thought his symptoms were related to a medical condition that needed further evaluation. Once he was transferred to the hospital on 7/25/23, she requested the staff to draw his neutrophil level so he could get his Clozaril medication refilled. In addition, she said R1 had an order for a neutrophil level on 7/2/23, but he refused. She agreed the nurse working on 7/2/23 should have documented the refusal on a progress note. Even though he refused his blood draw on 7/2/23, he still had Clozaril to take so they were not concerned. The nursing staff were unaware if the neutrophil level was not done, he would run out of the medication until it was done. On 7/17/23 NP-B visited R1 and ordered additional laboratory tests. The staff attempted to get the missing neutrophil level at the same time with the additional tests. When he refused to have his blood drawn on 7/19/23, refusal was not documented in R1's medical record and the laboratory staff did not tell anyone he refused to get his blood drawn. She felt the mistake occurred because the monthly neutrophil level</p>	F 740		

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F 740	<p>Continued From page 14</p> <p>was ordered 17 days before the next Clozaril refill, and the lack of nursing staff awareness before the pharmacy could provide more medication, they needed the test results.</p> <p>During an interview on 8/2/23 at 9:40 a.m., LPN-A stated when R1 refused to have his blood drawn the laboratory staff did not tell her. She added it was policy if a resident refused the blood drawn the laboratory staff was required to try on the next laboratory day and the staff did not have to submit an additional laboratory request form. She did not find out R1 missed a dose of Clozaril until 7/18/23, when she called the pharmacy and was notified, they were unable to refill his medication until they had a current neutrophil level. Since R1 already had the laboratory coming on 7/19/23 to draw his blood for different tests she would add on the neutrophil level. She documented on 7/26/23, she notified the facility NP because R1 refused to have his blood drawn and was out of Clozaril. She stated she never told RN-B they forgot to order the neutrophil test, but when she updated him on 7/26/23, he was more worried about having to do extra work. She confirmed information about R1's antipsychotic medication, target behaviors and required blood work associated with the medication should have been on the care plan.</p> <p>During an interview on 8/2/23 at 10:45 a.m., laboratory service staff (LSS)-A reviewed R1's laboratory history regarding all requests for a neutrophil level. She stated if a resident refused to have their blood drawn, the laboratory technician was responsible to notify the nursing staff and try again on the next laboratory day. She said most of the time facility's monitor for pending laboratory results and would call them to find out</p>	F 740		

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F 740	<p>Continued From page 15</p> <p>when the results would be ready for review. R1's facility had a contract with the laboratory to have blood drawn at the facility any day between Monday and Friday. She stated for the first week of July the facility did not request a neutrophil level for R1. The last time the facility ordered a neutrophil test was on 6/8/23. She stated her records showed each time R1 refused to have his blood drawn the laboratory technician did return to try again. Sometimes he agreed on the second attempt, but had he refused on the second attempt the facility would have to fill out another requisition form and fax it to the laboratory before they would come out again. According to her records R1 had an appointment for his blood to be drawn on 7/19/23, but according to the request form the box to order a neutrophil level was not checked. He did refuse to have his blood drawn on 7/19/23. The next neutrophil level was requested for 7/27/23, but later the facility canceled the test because R1 was in the hospital. She stated the facility has five laboratory days plus the capability to come out when a STAT (immediately) test is required.</p> <p>During an interview on 8/2/23 at 2:44: p.m., RN-B stated he is the nurse for psychiatrist(P)-A. He stated the nursing staff at the facility should have notified him immediately when he first refused to get his neutrophil level done. He stated they set up all of their patients who receive Clozaril with a company who draws the neutrophil level and if the level is within normal limits, they dispensed the medication. He was not sure why it became the facility's responsibility to order the neutrophil test and fax the results to the pharmacy. He said he was "shocked" to find out on 7/26/23 R1 did not receive his Clozaril for nine days and he felt the facility staff did not know what they were</p>	F 740		

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F 740	<p>Continued From page 16</p> <p>doing. he gave an example if a patient who received Haldol (another schizophrenic medication) every day and suddenly had no more medication what would you do? You would immediately call the pharmacy and if a laboratory test was needed you would do it right away to prevent any further missed dosages. He immediately reviewed the neutrophil level drawn on 7/25/23 and contacted a psychiatrist for new orders to titrate the medication up to the current 200 mg dose because he was off the medication for more than 48 hours. RN-B's main concern was R1's managed psychosis symptoms would worsen because he did not get the medication for nine days. R1's psychotic symptoms would include auditory and visual internal stimulation and paranoia, not the target behaviors identified at the facility. The facility staff should have notified P-A immediately when he did not get a neutrophil level prior to his next Clozaril refill, and the facility medical staff should have known the potential risk for abruptly stopping his antipsychotic medication.</p> <p>During an interview on 8/3/23 at 3:10 p.m., NP-B stated he did not have the qualification to order and monitor R1's Clozaril and instead the facility should have contacted R1's psychiatrist P-A</p> <p>During an interview on 8/3/23 at 3:59 p.m., the DON stated all consulting physicians to include psychiatrist should be identified with their contact information on the resident's face sheet. R1's psychiatrist was not identified because they did not know who it was, and they were waiting until the scheduled August appointment for a follow up visit to get their contact information. She stated the laboratory calendar book was a place for the staff to communicate with the laboratory staff for</p>	F 740		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245271</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/03/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROVIDENCE PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3720 23RD AVENUE SOUTH</b> <b>MINNEAPOLIS, MN 55407</b>		
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F 740	<p>Continued From page 17</p> <p>any new orders along with being a second check to ensure no orders were missed. When R1 refused to have his blood work drawn on 6/28/23, she did not force R1 to get his neutrophil level redrawn because it would only increase his agitation. She decided to wait until the next time he would have his blood work drawn which would have been on 7/19/23. She stated the Clozaril monitoring was set up by the hospital before he admitted to the facility in April. She stated she was unable to find R1's specific target behaviors so she asked her staff what behaviors they observed during his stay at the facility. The staff told her at times he can be physically or behaviorally aggressive. She said the nine missed doses could not have been a big deal since P-B wrote the titration to occur over three days. She was unaware of the consequences when a resident suddenly stops taking Clozaril until the pharmacy refused to send another refill. She added, the facility did not reorder the neutrophil test after 6/28/23 and 7/19/23, because they first needed R1's consent to do so. They were waiting for MHCM-A to be at the facility when they tried again. Once she was there and R1 consented they would have faxed a STAT request to the laboratory.</p> <p>During an interview on 8/3/23 at 8:15 a.m., LLS-B stated their laboratory does not accept any order to be done every four weeks. Instead, the facility was required to send a new requisition form every time. The facility laboratory book was for communication between the nursing and laboratory staff when any issue developed preventing them from drawing the residence blood. If a new order for additional blood work came in after the first requisition was faxed, they needed to send another requisition form to</p>	F 740		

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F 740	<p>Continued From page 18</p> <p>identify what test was needed. When a resident refuses to have his blood drawn two days in a row the order would be cancelled. The facility was required to submit another requisition form to get the laboratory staff to draw his blood. She added the 6/28/23, blood draw was refused, and the technician came back on 7/3/23 and successfully drew his blood. Because the facility failed to order a neutrophil test on the requisition form the lab only processed the test requested.</p> <p>During an interview on 8/3/23 at 9:00 a.m., MHCM-A stated the facility was responsible to manage his medical condition and follow doctor's orders. When R1 refused to get his blood drawn on 6/28/23 she did not know what laboratory test he refused but she did come in and talk to him and the test was redrawn successfully on 7/3/23. R1 probably refused the blood draw on 7/19/23 because he already had his blood drawn for the month because that is how it was set up in the past when he lived on his own. The SW called her on 7/20/23 to let her know R1 refused to have his blood drawn two days in a row. She did not know what test he refused, and she went straight to the facility to talk with R1. R1 told her he already had his blood drawn during the month. After talking to him he agreed to have his blood drawn the next time the laboratory staff came back to the facility. Had she known he needed a neutrophil test and his Clozaril was stopped on 7/17/23 she would have driven him to his psychiatrist office to get it drawn. She added the facility's target behavior monitoring only focused on one piece not the whole picture.</p> <p>During interview on 8/3/23 at 10:37 a.m., PH-A stated per FDA regulations any person receiving Clozaril required a monthly neutrophil test. He</p>	F 740		

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F 740	<p>Continued From page 19</p> <p>added people taking Clozaril did not get it by "accident." Only people with severe schizoaffective disorder and did not respond to the standard antipsychotic medication were prescribe Clozaril as a last-ditch effort. In addition, psychotic symptoms would include hallucinations, delusions, paranoia, or hearing voices. He confirmed R1's psychiatrist not the facility's medical providers should have been updated when he stopped getting his medication. He first learned about the medication error when he overheard the DON talking with the facility medical director (FMD)-A during an intradisciplinary meeting at the facility on 7/27/23. Lastly, when the facility failed to get a neutrophil test on 7/19/23 and 7/20/23 after two refusals they should have done something before the hospital visit on 7/25/23.</p> <p>During interview on 8/3/23 at 10:56 a.m., facility's medical director (FMD)-A who is responsible for the standard of care provided to the nursing home residents stated any patient taking Clozaril required a monthly neutrophil test before receiving additional refills. Clozaril is a heavy-duty medication that does not eliminate psychotic symptoms like hallucination, paranoia, and delusions, but it subdues the symptoms to a level where the patient can manage his disease. He added target behaviors are required by the Federal Drug Administration (FDA) and useful to detect increased psychotic symptoms and the need for an early intervention. He said only a psychiatrist or a medical physician who was certified by the Clozapine REMS (Risk Evaluation and Mitigation Strategy safety program) are able to monitor and prescribe Clozaril.</p> <p>During interview on 8/3/23 at 11:22 a.m., P-A</p>	F 740		

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F 740	<p>Continued From page 20</p> <p>stated she first learned about the missing doses when she came back from vacation on 8/1/23. R1 suffered a psychotic decompensation and decline when he stopped receiving his Clozaril after nine days. She stated in the past R1 stopped taking his medication when he lived on his own. In the past year she had noticed a cognitive decline common with schizoaffective patients leading him to forget to take his medication. Last time he was hospitalized for not taking his Clozaril was sometime during 2022. She added she never heard of a facility medical provider, a nursing home and their pharmacy manage any antipsychotic medication. She stated MHCM-A's responsibilities never included receiving information or concerns from the facility for the purpose of updating her office. When R1 did not receive a neutrophil test or a medication refill for nine days they should have communicated their concerns directly to her staff. She added MHCM-A has cared for R1 for fifteen years and had she known about the missing blood work and Clozaril doses she would have driven him to the hospital herself to have his blood drawn. R1 was one of their special patients and the staff were terribly upset when they heard about the missing doses and his consequent decline.</p> <p>During interview on 8/3/23 at 1:33 p.m., SW-A stated she had worked with MHCM-A since 2018 with various residents. She contacted her on 7/20/23, related to R1 refused to have his blood drawn. She did not tell MHCM-A which blood test he refused. MHCM-A reorganized her schedule so she could immediately come out to the facility and convince R1 to have his blood drawn the next time and he agreed. During the visit R1 was afraid someone was trying to push him into a white van, extremely paranoid and hyper-focused</p>	F 740		

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F 740	<p>Continued From page 21 about his surroundings.</p> <p>The facility laboratory's policy How to Use Your Calendar Book not dated indicated the book was provided by the laboratory to document the residents name and the laboratory test on the appropriate date it was due. When the laboratory staff arrived at the facility, they were responsible to first review the calendar book for changes or additions. If changes or additions are noted the laboratory staff were required to find the resident's nurse to clarify the discrepancy before drawing the individual's blood. If the blood is not drawn the laboratory staff would document the information on the calendar book.</p> <p>The facilities guide titled Appropriate Use of Psychotropic Drugs in Nursing Homes revised on 5/2014, indicated antipsychotic medication such as Clozaril required specific target behavior monitoring and quarterly AIMS Assessment for the treatment of Schizo-affective, Schizophrenia, psychotic mood disorders, and other mental health disorders. Indications for use for use/Target Behaviors included psychosis such as auditory, visual, or other hallucinations; delusions, paranoia, or grandiosity as well as behavioral symptoms that present a danger to self or others, behaviors that are inconsolable or persistent distress.</p>	F 740		

Minnesota Department of Health

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 8/1/23 through 8/3/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed during</p>	2 000		
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Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

08/22/23

Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>the survey. H52713802C(MN95347). H52714036C(MN95553).</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>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.</p>	2 000		