Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 25, 2024

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

RE: CCN: 245275
Cycle Start Date: March 21, 2024

Dear Administrator:

On April 15, 2024, the Minnesota Department of Health 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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 25, 2024

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

Re: Reinspection Results
Event ID: GOB712

Dear Administrator:

On April 15, 2024 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 March 21, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2024

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

RE: CCN: 245275
Cycle Start Date: March 21, 2024

Dear Administrator:

On March 21, 2024, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Annette Winters, Regional Operations Supervisor
Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: 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, 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 June 21, 2024 (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 September 21, 2024 (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) / 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:

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/ltc_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

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,

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

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Electronically delivered
April 1, 2024

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

Re: State Nursing Home Licensing Orders
Event ID: GOB711

Dear Administrator:

The above facility was surveyed on March 20, 2024 through March 21, 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:

Annette Winters, Regional Operations Supervisor
Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF EDINA	6200 XERXES AVENUE SOUTH MINNEAPOLIS, MN 55423

(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	INITIAL COMMENTS On 3/20/24 - 3/21/24, 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. The following complaints were reviewed with no deficiency issued. H52752282C (MN101423) The following complaints were reviewed. H52752123C (MN101665) with deficiency issued at F550 and F557. 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. 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.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		4/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/10/2024

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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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure R1 was allowed to exercise rights consistent with the comprehensive assessment and plan of care for 1 of 3 residents (R1) reviewed. R1 was her own representative who wanted to leave the facility after having smoking privileges revoked, was not an elopement risk, did not have dementia, and was	F 550	1. R1 has been discharged. 2. Discharge planning conversations occur at all care conferences. If a resident expresses a desire to transition to an alternate living location, either during a care conference, or during an unofficial conversation, social services will assist in planning and finding supportive services	

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F 550	Continued From page 2 not given assistance getting her needs met with her desire to leave. In addition, her smoking privileges were revoked without assistance to manage a safe smoking plan at the facility or assistance with smoking cessation tools. Findings include: R1's clinical resident profile dated 8/11/23 indicated R1 was her own responsible party. R1's care plan dated 8/18/23 indicated R1 was an elopement risk/wanderer and at risk to leave the facility without notice unauthorized related to history of repeatedly trying to exit the unit through the stairwell. R1's interventions were a discussion of the facility expectations: Signing out before leaving/out on pass or privileges may be restricted. This care plan problem was resolved on 12/6/24. R1's care plan dated 8/21/23 indicated R1 had multiple occurrences of smoking in the facility even after education and risk were explained. On 8/21/23 R1's interventions were: 1. R1 was instructed about the facility policy on smoking: location, times, and safety concerns. 2. R1 was instructed about smoking risks and smoking cessation aids that were available. 3. Notify charge nurse immediately if it is suspected R1 has violated the facility policy. On 2/26/24 R1's interventions were: 1. R1 was not allowed to smoke at the facility due to previous occurrences of smoking in the building. On 3/4/24 R1's interventions were: 1. A smoke alarm device was placed in R1's room. R1 was notified. The care plan did not indicate any interventions of	F 550	for them. Any other residents who have lost smoking privileges have been offered smoking cessation and it has been documented. In their medical record. 3. All Social Services Staff have been educated on a residents' right to choose their abode. All residents who have identified they would like to transfer to an alternate living situation are being assisted by the social services department with the assistance of community relocation services if needed. Our policy for All Social Services staff have been educated to document in a residents EMR when smoking privileges have been revoked and the types or support and cessation opportunities offered. 4. A list of all residents who are engaged in active discharge planning will be created. This will be updated weekly by social services to ensure progress is being made and steps are taken to relocate residents to their home of choice. Administrator, or designee, will audit this spreadsheet weekly for 4 weeks, then monthly for 4 months to ensure compliance. Results of audits will be reviewed at QAPI. Audits will be completed weekly on all residents who have smoking privileges revoked, to ensure smoking cessation and support have been offered and documented in the residents' EMR.	

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F 550	Continued From page 3 a plan to assist R1 with smoking or interventions to assist R1 with smoking cessation if her desires were to stop smoking. R1's progress notes from 12/7/23 - 1/3/24 indicated R1 had the Nicotine Transdermal patch 24-hour 14 mg/24 patched administered to her. There were no notes during that time indicating R1 refused the transdermal patch. This was the time R1 had Covid-19. R1's smoking assessment dated 9/14/24 at 11:10 a.m. indicated R1 was safe to smoke without supervision. R1 smoked cigarettes. The assessment indicated R1 had cognitive loss, no visual deficits, and no dexterity problems. R1 smoked 10+ cigarettes a day in the morning, afternoon, evening, and night. R1 could light her own cigarettes, she did not require any adaptive equipment. R1 did not need the facility to store her lighter or cigarettes. She was able to extinguish the cigarettes, get herself to the smoking area independently. R1 did not require the use of oxygen. An interdisciplinary decision note indicated R1 was safely able to store smoking products. She verbalized understanding of the policy on several occasions had been monitored for smoking in her room, which had not occurred recently. R1 was safe to smoke or use product noted without supervision. This assessment was the current smoking assessment on file for R1. R1's elopement risk assessment dated 12/14/23 at 2:35 p.m. indicated R1 was at low risk for elopement. R1's mental status indicated she could follow instructions, could communicate, could move without assistance while in a wheelchair. R1 did not have a diagnosis of	F 550	Audits will be reviewed at QAPI.	

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F 550	Continued From page 4 dementia and was cognitively intact. R1 had wandered/eloped/exit seeking within the past month. R1's social service progress note dated 12/19/23 at 4:17 p.m. indicated R1 was by the nurse's station with her belongings packed demanding her cigarettes and stated she was going to leave. When asked where she planned to go, she reported "home" and gave surrounding staff two different addresses when asked for further details. Resident was agitated towards nursing staff, continued to demand cigarettes and report that she was going home. Writer educated that she does not have doctor's order to discharge, and that the reason for staff securing cigarettes was due to safety concerns with her smoking in room being on isolation precautions. Resident also educated that if she were to leave, it would be AMA and educated on risks associated with discharging against AMA. The director of social services (SW)-B informed resident that she was unable to "walk" home, and that she would need reliable transportation. Resident told director of social services that she planned to return home and said that she was last there a month ago with her son. Staff were not able to verify if R1 still had her mobile home. R1 was previously deemed not safe to return to her mobile home by therapy and nursing due to cognitive concerns. R1 eventually agreed to go back to her room and refused any nicotine patches or gum. Family member (FM)-A to update on the situation. The note did not indicate that R1 was her own responsible part that she could leave the facility if she desired. Risks and benefits were not documented if she chose to leave and there was no documentation of offering R1 a leave of absence to visit her home. The note did not indicate when R1's	F 550		

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F 550	Continued From page 5	F 550		

cigarettes were taken from her and how she was able to smoke.

R1's behavior progress note dated 12/19/23 at 4:28 p.m. indicated R1 was alert and oriented to person, place, and time with confusion and forgetfulness. Patient was wheelchair bound and required assistance with ambulation. R1 was currently on Covid-19 isolation and was found smoking cigarettes twice in her room. R1 was offered nicotine patch but refused. R1 was redirected by staff during those two difference occasions the son was informed and spoke with R1. The director of nursing (DON), social services and the Administrator were notified.

R1's quarterly Minimum Data Set (MDS) assessment dated 12/28/23 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 13 indicating R1 was cognitively intact. R1's pertinent diagnoses were chronic diastolic (congestive) heart failure, pressure ulcer of the left heel, dependence on renal dialysis and long term (current) use of insulin.

R1's social service progress note dated 1/18/24 at 2:48 p.m. indicated R1 was recently observed smoking in building. Writer and social services director discussed with resident that her smoking materials will be kept with nurse's cart and that she is allowed one cigarette per request at a time to ensure safety. Resident verbally acknowledged that she understood and consented with both staff in the room for writer and social services director to remove smoking materials from room. There was smoke odor in bathroom, however unable to determine if resident had recently been smoking in there. Resident was also educated that if staff observe her smoking in building again

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F 550	Continued From page 6 or asking other peers who smoke for smoking materials that R1 will lose her smoking privileges. R1's behavioral progress note dated 1/26/24 at 11:02 a.m. indicated R1 had her belongings packed by the front door due to frustration with diet and fluid restriction. R1 reported that "she can drink and eat what she wants at home, so she may as well go home." Referred to registered dietician (RD) to review diet with the resident. R1 agreed to bring her belongings back up to her room and have a conversation with the RD. There was no documentation of a conversation with the RD. R1's social service progress note dated 2/26/24 at 1:31 p.m. indicated notification had been received that R1 was found smoking in her room. R1 had been given multiple opportunities to smoke in designated area and continued to exhibit behaviors of smoking in her room. R1 was her own responsible party, scored a 15/15 on BIMs assessed 2/26/24 and 23/30 on most recent SLUMS indicating a mild neurocognitive disorder. Social services notified three family members that R1's smoking privileges would be taken away effective 2/26/24 and that R1 may exhibit behavior of leaving the facility against medical advice (AMA) as evidenced by previous occurrences. Upon entering R1's room to discuss, R1 appeared to have door threshold blocked with clothing and bag and her room had strong cigarette odor. Both social service staff discussed revocation of smoking privileges with R1 and informed of room search for safety. R1 refused to give up handheld smoking materials and reported she was "going to smoke across the street." Social services explained the reasoning for revocation of privileges, R1 stated "she	F 550		

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F 550	Continued From page 7	F 550		

understood why" but "that staff cannot take her smoking materials." R1 exited the room to "go across the street to smoke." Both social service staff conducted the room search for safety, and found cigarette ends in bathroom and toilet. Staff also found unidentified medication that was removed and was given to nursing, along with two Ziplock bags; one with what appeared to be herbal marijuana and the other what appeared to be edible or wax with marijuana stamped on which was stored in the social service office. R1's care plan was updated to reflect that R1 was not allowed to smoke in the facility. The note did not indicate that R1 consented to the room search, or her items removed.

R1's nursing progress note dated 2/27/24 at 9:59 p.m. indicated R1 refused to go to dialysis today, got dressed for dialysis and decided not to go. Resident stated, she needs her cigarettes to smoke. If she cannot smoke, she will not go to dialysis. Nurse manager tried talking to resident about going to dialysis and was unsuccessful.

R1's nursing progress notes dated 2/29/24 at 7:24 p.m. indicated at 4:45 pm R1 was seen outside the building, with her personal belongings. Stated she was leaving and going home. Staffs was able to convince resident to come in the building and sit in the lobby. FM-A was called and gave her an update. FM-A called resident on her cellphone, and resident agreed to stay, and resident was ushered to her room. The note did not indicate any conversation with R1 about how long she wanted to go home if she required transportation and if she required medications.

R1's nursing progress note dated 3/4/24 indicated

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F 550	Continued From page 8 R1 was informed that a smoke alarm was placed in her room, she had no concerns at that time. The note did not indicate whether R1 was educated on why the smoke detector was in her room or she consented to the placement. R1's nursing progress note dated 3/7/24 at 3:30 p.m. indicated when R1 returned from dialysis, resident observed to be in the third-floor elevator talking to elevator call line in agitated manner. R1 was cussing and disruptive to care environment. Attempts to engaged with resident to attempt to deescalate. R1 inquired why her smoking materials were revoked, was explained this was due to smoking in room multiple times. R1 continued to remain agitated and reported she was "leaving this place and not coming back". Staff went with resident to the first floor where she went behind the front desk and used the facility phone. R1 appeared to be calling 911. R1 attempted to go towards the smoking patio and was redirected. R1 reported that she was leaving and not coming back, staff attempted to review AMA risks and paperwork with resident, she refused. R1 then self- propelled wheelchair and attempted to get to smoking patio from outdoors. Staff were able to redirect her, she was cussing and yelling on sidewalk. The police department arrived at facility responding to resident's phone call and talked with R1 and the staff about smoking. R1 reported she was going up to her room to "pack up her items as she's leaving." A one-to-one staff to patient assignment was initiated with R1 due to behaviors and a morning incident where R1 was verbally aggressed toward other residents on the smoking patio. The note did not indicate any interventions to assist R1 with going out to the smoking patio where she wanted to be.	F 550		

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F 550	Continued From page 9 R1's nursing progress note dated 3/7/24 at 7:22 p.m. indicated R1 left the facility AMA. Resident left the facility at about 6:20 p.m. R1 was educated about the cause of her action the AMA form to sign but she refused to sign. Write called FM-A. Writer called FM-B to talk to her R1 on the Phone. They had heated argument and she dropped the Phone. Writer called again and talked to her FM-B who promised to come and pick her mother. FM-B came but the R1 had left. The DON has also been updated. The note did not indicate what education was completed about AMA since R1 was her own decision maker. The note does indicate any interventions to assist R1 in leaving, or if an LOA was offered. R1's social service progress note dated 3/8/24 at 9:30 a.m. indicated FM-A called the facility and stated she is aware that R1 had left the facility AMA 3/7/24 and that R1's personal belongings were stored in an office and the facility will keep them for 30 days. R1's discharge summary/recap of stay dated 3/8/24 indicated R1 discharged by the facility AMA by herself without any transportation. R1 was alert and oriented to person, place, and time. R1 did not have a visual or hearing problems. R1 was agitated and refused cares. She was independent with dressing, grooming, toileting, bathing, bed mobility, transfer mobility and eating. No medications or no hard copies of prescriptions were given to R1. R1's summary indicated R1 was admitted to the facility. While at the facility she had scheduled dialysis and received support with medication management and meals. R1 was fairly independent with activities of daily living (ADL's). R1 had smoking privileges revoked due	F 550		

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F 550	Continued From page 10 to multiple times smoking in her room. R1 had behaviors of verbal aggression, refusing cares (dialysis), and unsafe smoking practices. R1 left the facility AMA on 3/7/24 at around 6:20 p.m. A Minnesota Adult Abuse Report Center (MAARC) report was filed, and the family was aware. An email correspondence dated 3/22/24 at 3:28 p.m. from the facility administrator included: 1. The AMA form filled out on 3/7/24 with the signature of LPN-C and an unidentified unreadable signature from another staff member. 2. A copy of an email from the NP to the DON dated 3/20/24 at 2:14 p.m. "In regards to R1 she had no desire to quite her cigarette use. She continuously declined smoking cessation and other forms of nicotine (patches, gum etc.) This was offered to her multiple times, but she declined." The statement does not indicate if R1 was offered cessation tools on 2/29/24 when the cigarettes were taken from her and per NP's above interview or accommodations of R1's smoking rights or right to leave the facility. 3. An email correspondence note from ACP dated 9/17/22 indicated R1's diagnoses from the evaluation were major depressive disorder, psychological factors affecting other medication conditions, borderline intellectual functioning, and unspecific neurocognitive disorder. The three recommendations were. 1. Continue to consult with general physician and psychiatric provider. 2. Continue consultation with behavioral health provider and complete another clinical examination when medically necessary. "There is no mention in his report of R1 needing a guardian or alternative decision maker." Upon interview on 3/20/24 at 9:20 a.m. family member (FM)-A stated that R1 did not have	F 550		

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F 550	Continued From page 11 dementia and was her own decision maker. She stated R1 was all "riled up" on 2/26/24 when the staff searched R1's room and took away her smoking privileges. She stated R1 called her multiple times a day following that incident. FM-A stated the reason R1 left the was facility was because the smoking privileges revoked. She stated she was aware "about a month ago" the staff was holding her cigarettes at the nurse's station so R1 would have to ask for a cigarette prior to smoking. FM-A was aware R1 did smoke in her room again and the smoking privileges were revoked, and was unaware if any other inventions, such as going out to smoke with her, asking her at different times to smoke or if any smoking cessation products were offered. She stated R1 had used a nicotine patch during Covid-19 in December of 2023. FM-A stated she was told by social worker (SW)-B that if R1 attempted to leave the facility staff would follow-up and the police would be called. FM-A stated on 3/7/24 R1 had left the facility and the staff returned R1 to the facility for "just being outside on the sidewalk." R1 left again at around 6:00 p.m. per a phone call from the facility. She stated R1 had resided at the facility for seven months and never tried to leave before her smoking was revoked. She stated R1 would come and go from dialysis a few times a week without concerns. Upon interview on 3/20/24 at 9:41 a.m. licensed practical nurse (LPN)-A stated R1's behaviors increased after her smoking had been revoked and the days prior to her leaving she was assigned a one-on-one for her behaviors, her safety and other residents' safety. On the evening of 3/7/24 R1 stated the nursing assistant (NA)-A, who was assigned to watch R1	F 550		

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F 550	Continued From page 12 one-on-one, took a break and at that point R1 left the facility. R1 had called the police officers because she was upset about not being to smoke and having a one-to-one assigned to her. After the facility noticed she had left the second time the facility called the police. Staff were searching for the facility inside and out. R1 was not certain why staff was searching for R1 since R1 was her own decision maker and able to come and go as she pleased. In addition, LPN-A was uncertain whether R1 was offered an LOA. Upon interview on 3/20/24 at 11:06 a.m. the Nurse Practitioner (NP) stated she had worked with R1 for four-five months. She stated R1's noncompliance with dialysis and medications became worse after her smoking privileges were revoked. She stated she did have "some" noncompliance prior to the smoking revocation. The NP stated she aware that R1 left, refused to sign the AMA paperwork. She stated R1 was safe to go out and smoke by herself and she did not have a guardian so was free to leave the facility when she wanted. She was not aware of anytime R1 left the facility without signing out or not letting the staff know she would be leaving. The NP stated she was unaware if the facility offered her any tools for smoking cessation stating, "I don't think she would have tried it anyway." The NP stated she did not hear that R1 wanted to return to the facility. The NP stated she was aware R1 was placed on a one-to-one assignment, she did not know the details or how long the one-to-one was to last. She stated, "I could see it coming that she would leave AMA." Upon interview on 3/20/23 at 11:26 a.m. registered nurse (RN)-B stated on 3/7/24 in the late afternoon R1 because upset because she	F 550		

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F 550	Continued From page 13 could not smoke, was assigned a one-on-one and had a conversation with her FM-B that "didn't go well." He stated around 6:00 p.m. NA-A, who was assigned to watch R1, went on a break and LPN-C was on the floor on the first floor of the facility and with R1 and then R1 left the facility. LPN-C stated he went to the third floor to look for R1 but could not find her. He called FM-A and had her call the police because the facility was searching for R1. LPN-C stated prior to R1 leaving he did try to get R1 to sign an AMA form, however she refused. LPN-C stated he called the DON about the "elopement" of R1 and let her know the facility was searching for R1. LPN-C stated he was aware that R1 was her own decision maker. He stated since she on a one-to-one assignment that her elopement was AMA. LPN-C stated he could not recall the conversation with the police because he was very busy. Upon interview on 3/20/24 at 12:17 p.m. NA-B stated she had worked with R1 during the day on the third floor and then worked on the first floor that evening. She stated about 6:15 p.m. the alarm went off that a resident had eloped, she assisted with the search. NA-B was not certain why the staff was searching for R1 since she could come and go as she pleased. Upon interview on 3/20/24 at 12:28 p.m. NA-A stated she was assigned to work a one-on-one shift with R1. She stated it was because R1 wanted to smoke, but she was no longer allowed to smoke at the facility. R1 wanted to go outside and see if some other residents would give her cigarettes, she stated she let her go outside and she called the DON. The DON told she could watch R1 from the inside because it was cold	F 550		

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F 550	Continued From page 14 outside. R1 about 5:30 p.m. called the police herself and they came and spoke with her and the nursing staff. R1 and LPN-C were both on the first floor when NA-A asked LPN-C to watch R1 so she could use the restroom. That was when R1 left the facility. NA-A stated she came back from the restroom and asked LPN-C where R1 went. She stated she called the DON and the DON wanted to speak with LPN-C, so NA-A went in search of R1. Upon interview on 3/20/24 at 2:04 p.m. social worker (SW)-A stated R1 had a BIMs of 15 when it was assessed on 2/29/24, did not have a diagnosis of dementia, was not assessed an elopement risk and was her own decision maker. SW-A stated R1 could come and go as she pleased, so the reason it was considered an AMA elopement was because R1 left without the facility getting orders from the physician. She stated she was aware that R1 had been agitated since the smoking privileges had been revoked. SW-A was not aware of any behavior plan or any discussion of a safe discharge plan since R1 could no longer smoke at the facility. She stated she "thought" nursing had offered smoking cessation tools, as she was aware R1 wore a patch when she could not smoke during Covid. She was unable to find any documentation of attempts for smoking cessation. Upon interview on 3/21/24 at 9:29 a.m. R1 stated "I just walked out." R1 stated the reason she left was because the facility took her cigarettes away and had "an aide following me around." She stated on the evening of 3/7/24 when the NA-B went on a break and LPN-C was on the phone she walked out the door. She stated she had her coat on, pajama pants and her shoes. She	F 550		

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F 550	Continued From page 15 walked to the bus stop and got on the bus. The bus took her to downtown and from there she got on another bus to get her home. She stated she arrived at her home about 10:00 p.m. Upon interview on 3/21/24 at 11:13 a.m. R2 stated she recalled the day of 3/7/24 because R1 was asking for cigarettes out on the smoking patio and when R2 stated she could not give R1 any cigarettes because she did not want to lose her smoking privileges, R1 called her a "bitch." She stated she was aware that R1 left the facility that same evening and has not been seen since. She stated ever since the facility took away R1's smoking privileges, R1 would beg other smokers on the patio for cigarettes and even take used cigarette butts and smoke. "It was very sad to watch." Upon interview on 3/21/24 at 12:18 p.m. R3 stated he knew R1, and she told him the facility took her cigarettes away. He witnessed her always begging other residents for cigarettes. He stated he witnessed her more than once tip over the ash canisters, pick up the butts from the ground and smoke them. R3 stated he did report this to LPN-B because it was disturbing to the other smokers. Upon interview on 3/21/24 at 12:56 p.m. LPN-B stated she did recall a few residents tell her that R1 was dumping over the ash canisters and smoking the butts. She stated the week R1's privileges were revoked was a "big deal" to R1 she started talking about wanting to go home, had increased agitation. She stated it was hard on the staff because R1 to come and go as she pleased. She stated she was unaware if R1 had been offered tools for smoking cessation, and	F 550		

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F 550	Continued From page 16 stated she did not have patches or nicotine gum on the cart to be as needed if R1 did request some. Upon interview on 3/21/24 at 1:31 p.m. RN-A stated the facility accommodates planned and unplanned leave of absences, but R1's response was she was not coming back. He denied any knowledge of the facilities attempt to provide a safe discharge. He stated the reason R1's elopement was considered AMA was because she was leaving, not coming back and there were no provider orders. LPN-C was aware that R1 had been asking to leave since 2/29/24. Upon interview on 3/21/24 at 1:55 p.m. the DON stated R1 was her own person, the provider and the team was aware that she was her own decision maker and made her own decisions. She denied any involvement with R1's discharge planning, deferring those questions to social services. She stated there were multiple occasions where the staff needed to redirect R1 for smoking in her room. R1 had been given education and policy reviewed. She stated for or a time R1 had her smoking materials with nursing staff so at least she could have the right to smoke. On 3/4/24 a smoke alarm was placed in R1's room. The incident on 2/29/24 started with an unidentified staff member reported they smelled smoke in R1's The DON stated R1 voluntarily allowed the staff to search her room. They found cigarette ends and identified some herbal marijuana the tablets in a plastic bag. She stated the facility attempted "many" interventions with R1. The DON stated the facility intervened by having R1's cigarettes left with nurses, with no restrictions, no limit her access to how many times she could out and smoke. When her	F 550		

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F 550	Continued From page 17 privileges were revoked it was for her safety the safety of other residents. She stated the provider offered her nicotine patches; she did not want to quit smoking. She did wear the patches during Covid. R1 had a history of refusing cares. She was her own person, and she had the right to make those decisions. The DON stated she was made aware a resident was upset about the smoking being revoked uncertain of the date. She stated the reason R1 was put on a one-to-one assignment on 3/7/24 was with a goal in mind to observe behaviors from R1 after calling R1 a "bitch" when R1 was begging for cigarettes on the smoking patio from R2 and after the observations they facility would get Associated Clinic of Psychiatry (ACP) involved for immediate interventions. The DON stated she was certain that an LOA was not R1's intention because R1 stated she was leaving and not coming back. She stated R1 was informed if she left and does not take her personal items the facility would store them for 30 days. The DON stated she explained to R1 the facility would not be able to give her medications or set-up her services for her. The DON stated the day of 3/7/24 was the first time she heard R1 wanted to leave the facility. The DON stated she was not aware, nor did she order the facility staff to search R1's room. A facility policy titled Resident Rights dated 10/24/23 indicated residents have the right to request, refuse and/or discontinue treatment prescribed by their healthcare provider, as well as care routines outline on the resident's assessment and plan of care. A facility policy titled Smoking and E-Cigarettes revised on 3/9/22 indicated facility will complete an assessment when a resident request to	F 550		

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F 550	Continued From page 18 smoking, to determine the level of supervision, assistance, and individualized approaches for safety. In addition, the Smoking Policy outlines the designated areas, notices, education, and requirements for smoking on the facility property to ensure precautions are taken for the resident's individual safety as well as the safety of others in the facility. The facility does indicate revoking a resident's smoking rights.	F 550		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain respect and dignity for personal possessions for 1 of 3 resident's (R1) reviewed who had her room searched and items removed without consent. Findings include: R1's clinical resident profile dated 8/11/23 indicated R1 was her own responsible party. R1's quarterly Minimum Data Set (MDS) assessment dated 12/28/23 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 13 indicating R1 was cognitively intact. R1's	F 557	1. R1 has been discharged. 2. All residents have the potential to be affected. 3. All social services staff have been educated on conducting a proper search, obtaining consent, and documentation in the EMR. Our policy for room search was reviewed with no changes made. 4. Audits will be completed after each room search initiated to ensure all steps of the process were completed. Audits will remain ongoing until IDT, through QAPI, deem appropriate to discontinue. Administrator or designee is responsible for the audits. Results of the audits will be	4/12/24

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F 557	Continued From page 19 pertinent diagnoses were chronic diastolic (congestive) heart failure, pressure ulcer of the left heel, dependence on renal dialysis and long term (current) use of insulin. R1's elopement risk assessment dated 12/14/23 at 2:35 p.m. indicated R1 was at low risk for elopement. R1's mental status indicated she could follow instructions, could communicate, could move without assistance while in a wheelchair. R1 did not have a diagnosis of dementia and was cognitively intact. R1 had wandered/eloped/exit seeking within the past month. R1's social service progress note dated 2/26/24 at 1:31 p.m. indicated notification had been received that R1 was found smoking in her room. R1 had been given multiple opportunities to smoke in designated area and continued to exhibit behaviors of smoking in her room. R1 was her own responsible party, scored a 15/15 on BIMs assessed 2/26/24 and 23/30 on most recent SLUMS indicating a mild neurocognitive disorder. Social services notified three family members that R1's smoking privileges would be taken away effective 2/26/24 and that R1 may exhibit behavior of leaving the facility against medical advice (AMA) as evidenced by previous occurrences. Upon entering R1's room to discuss, R1 appeared to have door threshold blocked with clothing and bag and her room had strong cigarette odor. Both social service staff discussed revocation of smoking privileges with R1 and informed of room search for safety. R1 refused to give up handheld smoking materials and reported she was "going to smoke across the street." Social services explained the reasoning for revocation of privileges, R1 stated "she	F 557	reviewed at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING _____ B. WING _____	C 03/21/2024

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F 557	Continued From page 20 understood why" but "that staff cannot take her smoking materials." R1 exited the room to "go across the street to smoke." Both social service staff conducted the room search for safety, and found cigarette ends in bathroom and toilet. Staff also found unidentified medication that was removed and was given to nursing, along with two Ziplock bags; one with what appeared to be herbal marijuana and the other what appeared to be edible or wax with marijuana stamped on which was stored in the social service office. R1's care plan was updated to reflect that R1 was not allowed to smoke in the facility. The note did not indicate that R1 consented to the room search. Upon interview on 3/20/24 at 9:20 a.m. family member (FM)-A stated that R1 called her multiple times on 2/26/24 after her room was searched and her smoking privileges revoked. R1 stated to FM-A that her room was searched, and some items were taken without her permission. "She stated to me that staff were going to search her room no matter what, so she left with the cigarettes in her hands and went outside." Upon interview on 3/21/24 at 9:29 a.m. R1 stated left the facility because of "how she was treated." She stated she told multiple staff members she wanted to be discharged after her smoking privileges were taken away, her room was searched, and her things were taken without her permission. She stated, "I had no choice with what they were going to do." Upon interview on 3/21/24 at 1:15 p.m. SW-B stated it depends on the need of how staff search a resident's room. He stated staff will search the room if the resident is posing a risk to themselves	F 557		

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F 557	Continued From page 21 or another resident. He stated it had was reported that R1 had been smoking in her room "again." SW-B could not recall who made the complaint or when the complaint was made of R1 smoking in her room. He stated the report was that there was a strong cigarette smell. He was not certain if any residents or staff witnessed R1 smoking in her room. SW-B stated the staff did ask R1 for her consent, but he did not recall R1's response, as she was often belligerent. He recalled R1 left the room saying, "F this, I am going outside to smoke." SW-B stated he told R1 she was not safe to cross the street on her own. R1 left the room seated on her walker, pushing herself backwards and went across the street from the facility to smoke. Upon interview on 3/21/24 at 1:38 p.m. social worker (SW)-A stated she did not recall how she heard R1 was smoking in her room. She stated she did not recall exactly how R1 was asked for permission but stated "we would have asked for permission, and it would have been verbal." SW-A denied awareness of any policy indicating staff must receive consent prior to a room search. Upon interview on 3/21/24 at 1:55 p.m. the director of nursing stated the staff R1 voluntarily allowed the staff to search her room. She stated she knew that because the social service department had stated it was in her progress notes. The facilities Resident Rights: Dignity policy did not indicate anything regarding searching of resident's rooms. A policy on searching of residents' rooms was requested and an email from the administrator	F 557		

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F 557	Continued From page 22 was obtained on 3/21/24 at 1:54 p.m. the email indicated the facility did not have a room search policy. The administrator indicated the facility follows the State Operations Manual (SOM) and posted a copy from page 30 of the SOM Appendix PP2023 version: "Visitation and Illegal Substance Use It is important for facility staff to have knowledge of signs, symptoms, and triggers of possible illegal substance use such as changes in resident behavior, particularly after interaction with visitors or leaves of absence, increased unexplained drowsiness, lack of coordination, slurred speech, mood changes, and/or loss of consciousness, etc. Following such occurrences, this may include asking residents, who appear to have used an illegal substance (e.g., cocaine, hallucinogens, heroin), whether they possess or have used an illegal substance. If the facility determines illegal substances have been brought into the facility by a visitor, the facility should not act as an arm of law enforcement. Rather, in accordance with state laws, these cases may warrant a referral to local law enforcement. To protect the health and safety of residents, facilities may need to provide additional monitoring and supervision. Additionally, facility staff should not conduct searches of a resident or their personal belongings, unless the resident or resident representative agrees to a voluntary search and understands the reason for the search. For concerns related to the identification of risk and the provision of supervision to prevent accidental overdose, investigate potential non-compliance at F689, §483.25(d)"	F 557		

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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 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 3/20/24 - 3/21/24, a complaint 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 licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H52752282C (MN101423) The following complaints were reviewed. H52752123C (MN101665) with a licensing order issued at 1805 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 surveyor's 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 14-01, available at 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 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interviews and record review the facility failed to ensure R1 was allowed to exercise rights consistent with the comprehensive assessment and plan of care for 1 of 3 residents (R1) reviewed. R1 was her own representative who wanted to leave the facility after having smoking privileges revoked, was not an elopement risk, did not have dementia, and was not given assistance getting her needs met with her desire to leave. In addition, her smoking privileges were revoked without assistance to manage a safe smoking plan at the facility or assistance with smoking cessation tools. Findings include:	21805	Corrected	4/12/24

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21805	Continued From page 3 R1's clinical resident profile dated 8/11/23 indicated R1 was her own responsible party. R1's care plan dated 8/18/23 indicated R1 was an elopement risk/wanderer and at risk to leave the facility without notice unauthorized related to history of repeatedly trying to exit the unit through the stairwell. R1's interventions were a discussion of the facility expectations: Signing out before leaving/out on pass or privileges may be restricted. This care plan problem was resolved on 12/6/24. R1's care plan dated 8/21/23 indicated R1 had multiple occurrences of smoking in the facility even after education and risk were explained. On 8/21/23 R1's interventions were: 1. R1 was instructed about the facility policy on smoking: location, times, and safety concerns. 2. R1 was instructed about smoking risks and smoking cessation aids that were available. 3. Notify charge nurse immediately if it is suspected R1 has violated the facility policy. On 2/26/24 R1's interventions were: 1. R1 was not allowed to smoke at the facility due to previous occurrences of smoking in the building. On 3/4/24 R1's interventions were: 1. A smoke alarm device was placed in R1's room. R1 was notified. The care plan did not indicate any interventions of a plan to assist R1 with smoking or interventions to assist R1 with smoking cessation if her desires were to stop smoking. R1's progress notes from 12/7/23 - 1/3/24 indicated R1 had the Nicotine Transdermal patch 24-hour 14 mg/24 patched administered to her. There were no notes during that time indicating R1 refused the transdermal patch. This was the	21805		

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21805	Continued From page 4 time R1 had Covid-19. R1's smoking assessment dated 9/14/24 at 11:10 a.m. indicated R1 was safe to smoke without supervision. R1 smoked cigarettes. The assessment indicated R1 had cognitive loss, no visual deficits, and no dexterity problems. R1 smoked 10+ cigarettes a day in the morning, afternoon, evening, and night. R1 could light her own cigarettes, she did not require any adaptive equipment. R1 did not need the facility to store her lighter or cigarettes. She was able to extinguish the cigarettes, get herself to the smoking area independently. R1 did not require the use of oxygen. An interdisciplinary decision note indicated R1 was safely able to store smoking products. She verbalized understanding of the policy on several occasions had been monitored for smoking in her room, which had not occurred recently. R1 was safe to smoke or use product noted without supervision. This assessment was the current smoking assessment on file for R1. R1's elopement risk assessment dated 12/14/23 at 2:35 p.m. indicated R1 was at low risk for elopement. R1's mental status indicated she could follow instructions, could communicate, could move without assistance while in a wheelchair. R1 did not have a diagnosis of dementia and was cognitively intact. R1 had wandered/eloped/exit seeking within the past month. R1's social service progress note dated 12/19/23 at 4:17 p.m. indicated R1 was by the nurse's station with her belongings packed demanding her cigarettes and stated she was going to leave. When asked where she planned to go, she reported "home" and gave surrounding staff two	21805		

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21805	Continued From page 5 different addresses when asked for further details. Resident was agitated towards nursing staff, continued to demand cigarettes and report that she was going home. Writer educated that she does not have doctor's order to discharge, and that the reason for staff securing cigarettes was due to safety concerns with her smoking in room being on isolation precautions. Resident also educated that if she were to leave, it would be AMA and educated on risks associated with discharging against AMA. The director of social services (SW)-B informed resident that she was unable to "walk" home, and that she would need reliable transportation. Resident told director of social services that she planned to return home and said that she was last there a month ago with her son. Staff were not able to verify if R1 still had her mobile home. R1 was previously deemed not safe to return to her mobile home by therapy and nursing due to cognitive concerns. R1 eventually agreed to go back to her room and refused any nicotine patches or gum. Family member (FM)-A to update on the situation. The note did not indicate that R1 was her own responsible part that she could leave the facility if she desired. Risks and benefits were not documented if she chose to leave and there was no documentation of offering R1 a leave of absence to visit her home. The note did not indicate when R1's cigarettes were taken from her and how she was able to smoke. R1's behavior progress note dated 12/19/23 at 4:28 p.m. indicated R1 was alert and oriented to person, place, and time with confusion and forgetfulness. Patient was wheelchair bound and required assistance with ambulation. R1 was currently on Covid-19 isolation and was found smoking cigarettes twice in her room. R1 was offered nicotine patch but refused. R1 was	21805		

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21805	Continued From page 6 redirected by staff during those two difference occasions the son was informed and spoke with R1. The director of nursing (DON), social services and the Administrator were notified. R1's quarterly Minimum Data Set (MDS) assessment dated 12/28/23 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 13 indicating R1 was cognitively intact. R1's pertinent diagnoses were chronic diastolic (congestive) heart failure, pressure ulcer of the left heel, dependence on renal dialysis and long term (current) use of insulin. R1's social service progress note dated 1/18/24 at 2:48 p.m. indicated R1 was recently observed smoking in building. Writer and social services director discussed with resident that her smoking materials will be kept with nurse's cart and that she is allowed one cigarette per request at a time to ensure safety. Resident verbally acknowledged that she understood and consented with both staff in the room for writer and social services director to remove smoking materials from room. There was smoke odor in bathroom, however unable to determine if resident had recently been smoking in there. Resident was also educated that if staff observe her smoking in building again or asking other peers who smoke for smoking materials that R1 will lose her smoking privileges. R1's behavioral progress note dated 1/26/24 at 11:02 a.m. indicated R1 had her belongings packed by the front door due to frustration with diet and fluid restriction. R1 reported that "she can drink and eat what she wants at home, so she may as well go home." Referred to registered dietician (RD) to review diet with the resident. R1 agreed to bring her belongings back up to her room and have a conversation with the	21805		

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21805	Continued From page 7 RD. There was no documentation of a conversation with the RD. R1's social service progress note dated 2/26/24 at 1:31 p.m. indicated notification had been received that R1 was found smoking in her room. R1 had been given multiple opportunities to smoke in designated area and continued to exhibit behaviors of smoking in her room. R1 was her own responsible party, scored a 15/15 on BIMs assessed 2/26/24 and 23/30 on most recent SLUMS indicating a mild neurocognitive disorder. Social services notified both family members, and R1's sister that R1's smoking privileges would be taken away effective 2/26/24 and that R1 may exhibit behavior of leaving the facility against medical advice (AMA) as evidenced by previous occurrences. Upon entering R1's room to discuss, R1 appeared to have door threshold blocked with clothing and bag and her room had strong cigarette odor. Both social service staff discussed revocation of smoking privileges with R1 and informed of room search for safety. R1 refused to give up handheld smoking materials and reported she was "going to smoke across the street." Social services explained the reasoning for revocation of privileges, R1 stated "she understood why" but "that staff cannot take her smoking materials." R1 exited the room to "go across the street to smoke." Both social service staff conducted the room search for safety, and found cigarette ends in bathroom and toilet. Staff also found unidentified medication that was removed and was given to nursing, along with two Ziplock bags; one with what appeared to be herbal marijuana and the other what appeared to be edible or wax with marijuana stamped on which was stored in the social service office. R1's care plan was updated to reflect that R1 was not allowed to smoke in the facility. The note did	21805		

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21805	Continued From page 8 not indicate that R1 consented to the room search, or her items removed. R1's nursing progress note dated 2/27/24 at 9:59 p.m. indicated R1 refused to go to dialysis today, got dressed for dialysis and decided not to go. Resident stated, she needs her cigarettes to smoke. If she cannot smoke, she will not go to dialysis. Nurse manager tried talking to resident about going to dialysis and was unsuccessful. R1's nursing progress notes dated 2/29/24 at 7:24 p.m. indicated at 4:45 pm R1 was seen outside the building, with her personal belongings. Stated she was leaving and going home. Staffs was able to convince resident to come in the building and sit in the lobby. FM-A was called and gave her an update. FM-A called resident on her cellphone, and resident agreed to stay, and resident was ushered to her room. The note did not indicate any conversation with R1 about how long she wanted to go home if she required transportation and if she required medications. R1's nursing progress note dated 3/4/24 indicated R1 was informed that a smoke alarm was placed in her room, she had no concerns at that time. The note did not indicate whether R1 was educated on why the smoke detector was in her room or she consented to the placement. R1's nursing progress note dated 3/7/24 at 3:30 p.m. indicated when R1 returned from dialysis, resident observed to be in the third-floor elevator talking to elevator call line in agitated manner. R1 was cussing and disruptive to care environment. Attempts to engaged with resident to attempt to deescalate. R1 inquired why her smoking materials were revoked, was explained this was	21805		

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21805	Continued From page 9 due to smoking in room multiple times. R1 continued to remain agitated and reported she was "leaving this place and not coming back". Staff went with resident to the first floor where she went behind the front desk and used the facility phone. R1 appeared to be calling 911. R1 attempted to go towards the smoking patio and was redirected. R1 reported that she was leaving and not coming back, staff attempted to review AMA risks and paperwork with resident, she refused. R1 then self- propelled wheelchair and attempted to get to smoking patio from outdoors. Staff were able to redirect her, she was cussing and yelling on sidewalk. The police department arrived at facility responding to resident's phone call and talked with R1 and the staff about smoking. R1 reported she was going up to her room to "pack up her items as she's leaving." A one-to-one staff to patient assignment was initiated with R1 due to behaviors and a morning incident where R1 was verbally aggressed toward other residents on the smoking patio. The note did not indicate any interventions to assist R1 with going out to the smoking patio where she wanted to be. R1's nursing progress note dated 3/7/24 at 7:22 p.m. indicated R1 left the facility AMA. Resident left the facility at about 6:20 p.m. R1 was educated about the cause of her action the AMA form to sign but she refused to sign. Write called FM-A. Writer called FM-B to talk to her R1 on the Phone. They had heated argument and she dropped the Phone. Writer called again and talked to her FM-B who promised to come and pick her mother. FM-B came but the R1 had left. The DON has also been updated. The note did not indicate what education was completed about AMA since R1 was her own decision maker. The note does indicate any interventions to assist R1	21805		

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	00740	A. BUILDING: _____ B. WING _____	C 03/21/2024

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21805	Continued From page 10 in leaving, or if an LOA was offered. R1's social service progress note dated 3/8/24 at 9:30 a.m. indicated FM-A called the facility and stated she is aware that R1 had left the facility AMA 3/7/24 and that R1's personal belongings were stored in an office and the facility will keep them for 30 days. R1's discharge summary/recap of stay dated 3/8/24 indicated R1 discharged by the facility AMA by herself without any transportation. R1 was alert and oriented to person, place, and time. R1 did not have a visual or hearing problems. R1 was agitated and refused cares. She was independent with dressing, grooming, toileting, bathing, bed mobility, transfer mobility and eating. No medications or no hard copies of prescriptions were given to R1. R1's summary indicated R1 was admitted to the facility. While at the facility she had scheduled dialysis and received support with medication management and meals. R1 was fairly independent with activities of daily living (ADL's). R1 had smoking privileges revoked due to multiple times smoking in her room. R1 had behaviors of verbal aggression, refusing cares (dialysis), and unsafe smoking practices. R1 left the facility AMA on 3/7/24 at around 6:20 p.m. A Minnesota Adult Abuse Report Center (MAARC) report was filed, and the family was aware. An email correspondence dated 3/22/24 at 3:28 p.m. from the facility administrator included: 1. The AMA form filled out on 3/7/24 with the signature of LPN-C and an unidentified unreadable signature from another staff member. 2. A copy of an email from the NP to the DON dated 3/20/24 at 2:14 p.m. "In regards to R1 she had no desire to quite her cigarette use. She continuously declined smoking cessation and	21805		

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21805	Continued From page 11 other forms of nicotine (patches, gum etc.) This was offered to her multiple times, but she declined." The statement does not indicate if R1 was offered cessation tools on 2/29/24 when the cigarettes were taken from her and per NP's above interview or accommodations of R1's smoking rights or right to leave the facility. 3. An email correspondence note from ACP dated 9/17/22 indicated R1's diagnoses from the evaluation were major depressive disorder, psychological factors affecting other medication conditions, borderline intellectual functioning, and unspecific neurocognitive disorder. The three recommendations were. 1. Continue to consult with general physician and psychiatric provider. 2. Continue consultation with behavioral health provider and complete another clinical examination when medically necessary. "There is no mention in his report of R1 needing a guardian or alternative decision maker." Upon interview on 3/20/24 at 9:20 a.m. family member (FM)-A stated that R1 did not have dementia and was her own decision maker. She stated R1 was all "riled up" on 2/26/24 when the staff searched R1's room and took away her smoking privileges. She stated R1 called her multiple times a day following that incident. FM-A stated the reason R1 left the was facility was because the smoking privileges revoked. She stated she was aware "about a month ago" the staff was holding her cigarettes at the nurse's station so R1 would have to ask for a cigarette prior to smoking. FM-A was aware R1 did smoke in her room again and the smoking privileges were revoked, and was unaware if any other inventions, such as going out to smoke with her, asking her at different times to smoke or if any smoking cessation products were offered. She stated R1 had used a nicotine patch during	21805		

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21805	Continued From page 12 Covid-19 in December of 2023. FM-A stated she was told by social worker (SW)-B that if R1 attempted to leave the facility staff would follow-up and the police would be called. FM-A stated on 3/7/24 R1 had left the facility and the staff returned R1 to the facility for "just being outside on the sidewalk." R1 left again at around 6:00 p.m. per a phone call from the facility. She stated R1 had resided at the facility for seven months and never tried to leave before her smoking was revoked. She stated R1 would come and go from dialysis a few times a week without concerns. Upon interview on 3/20/24 at 9:41 a.m. licensed practical nurse (LPN)-A stated R1's behaviors increased after her smoking had been revoked and the days prior to her leaving she was assigned a one-on-one for her behaviors, her safety and other residents' safety. On the evening of 3/7/24 R1 stated the nursing assistant (NA)-A, who was assigned to watch R1 one-on-one, took a break and at that point R1 left the facility. R1 had called the police officers because she was upset about not being to smoke and having a one-to-one assigned to her. After the facility noticed she had left the second time the facility called the police. Staff were searching for the facility inside and out. R1 was not certain why staff was searching for R1 since R1 was her own decision maker and able to come and go as she pleased. In addition, LPN-A was uncertain whether R1 was offered an LOA. Upon interview on 3/20/24 at 11:06 a.m. the Nurse Practitioner (NP) stated she had worked with R1 for four-five months. She stated R1's noncompliance with dialysis and medications became worse after her smoking privileges were revoked. She stated she did have "some"	21805		

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21805	Continued From page 13 noncompliance prior to the smoking revocation. The NP stated she aware that R1 left, refused to sign the AMA paperwork. She stated R1 was safe to go out and smoke by herself and she did not have a guardian so was free to leave the facility when she wanted. She was not aware of anytime R1 left the facility without signing out or not letting the staff know she would be leaving. The NP stated she was unaware if the facility offered her any tools for smoking cessation stating, "I don't think she would have tried it anyway." The NP stated she did not hear that R1 wanted to return to the facility. The NP stated she was aware R1 was placed on a one-to-one assignment, she did not know the details or how long the one-to-one was to last. She stated, "I could see it coming that she would leave AMA." Upon interview on 3/20/23 at 11:26 a.m. registered nurse (RN)-B stated on 3/7/24 in the late afternoon R1 because upset because she could not smoke, was assigned a one-on-one and had a conversation with her FM-B that "didn't go well." He stated around 6:00 p.m. NA-A, who was assigned to watch R1, went on a break and LPN-C was on the floor on the first floor of the facility and with R1 and then R1 left the facility. LPN-C stated he went to the third floor to look for R1 but could not find her. He called FM-A and had her call the police because the facility was searching for R1. LPN-C stated prior to R1 leaving he did try to get R1 to sign an AMA form, however she refused. LPN-C stated he called the DON about the "elopement" of R1 and let her know the facility was searching for R1. LPN-C stated he was aware that R1 was her own decision maker. He stated since she on a one-to-one assignment that her elopement was AMA. LPN-C stated he could not recall the conversation with the police because he was very	21805		

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21805	Continued From page 14 busy. Upon interview on 3/20/24 at 12:17 p.m. NA-B stated she had worked with R1 during the day on the third floor and then worked on the first floor that evening. She stated about 6:15 p.m. the alarm went off that a resident had eloped, she assisted with the search. NA-B was not certain why the staff was searching for R1 since she could come and go as she pleased. Upon interview on 3/20/24 at 12:28 p.m. NA-A stated she was assigned to work a one-on-one shift with R1. She stated it was because R1 wanted to smoke, but she was no longer allowed to smoke at the facility. R1 wanted to go outside and see if some other residents would give her cigarettes, she stated she let her go outside and she called the DON. The DON told she could watch R1 from the inside because it was cold outside. R1 about 5:30 p.m. called the police herself and they came and spoke with her and the nursing staff. R1 and LPN-C were both on the first floor when NA-A asked LPN-C to watch R1 so she could use the restroom. That was when R1 left the facility. NA-A stated she came back from the restroom and asked LPN-C where R1 went. She stated she called the DON and the DON wanted to speak with LPN-C, so NA-A went in search of R1. Upon interview on 3/20/24 at 2:04 p.m. social worker (SW)-A stated R1 had a BIMs of 15 when it was assessed on 2/29/24, did not have a diagnosis of dementia, was not assessed an elopement risk and was her own decision maker. SW-A stated R1 could come and go as she pleased, so the reason it was considered an AMA elopement was because R1 left without the facility getting orders from the physician. She stated	21805		

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21805	Continued From page 15 she was aware that R1 had been agitated since the smoking privileges had been revoked. SW-A was not aware of any behavior plan or any discussion of a safe discharge plan since R1 could no longer smoke at the facility. She stated she "thought" nursing had offered smoking cessation tools, as she was aware R1 wore a patch when she could not smoke during Covid. She was unable to find any documentation of attempts for smoking cessation. Upon interview on 3/21/24 at 9:29 a.m. R1 stated "I just walked out." R1 stated the reason she left was because the facility took her cigarettes away and had "an aide following me around." She stated on the evening of 3/7/24 when the NA-B went on a break and LPN-C was on the phone she walked out the door. She stated she had her coat on, pajama pants and her shoes. She walked to the bus stop and got on the bus. The bus took her to downtown and from there she got on another bus to get her home. She stated she arrived at her home about 10:00 p.m. Upon interview on 3/21/24 at 11:13 a.m. R2 stated she recalled the day of 3/7/24 because R1 was asking for cigarettes out on the smoking patio and when R2 stated she could not give R1 any cigarettes because she did not want to lose her smoking privileges, R1 called her a "bitch." She stated she was aware that R1 left the facility that same evening and has not been seen since. She stated ever since the facility took away R1's smoking privileges, R1 would beg other smokers on the patio for cigarettes and even take used cigarette butts and smoke. "It was very sad to watch." Upon interview on 3/21/24 at 12:18 p.m. R3 stated he knew R1, and she told him the facility	21805		

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21805	Continued From page 16 took her cigarettes away. He witnessed her always begging other residents for cigarettes. He stated he witnessed her more than once tip over the ash canisters, pick up the butts from the ground and smoke them. R3 stated he did report this to LPN-B because it was disturbing to the other smokers. Upon interview on 3/21/24 at 12:56 p.m. LPN-B stated she did recall a few residents tell her that R1 was dumping over the ash canisters and smoking the butts. She stated the week R1's privileges were revoked was a "big deal" to R1 she started talking about wanting to go home, had increased agitation. She stated it was hard on the staff because R1 to come and go as she pleased. She stated she was unaware if R1 had been offered tools for smoking cessation, and stated she did not have patches or nicotine gum on the cart to be as needed if R1 did request some. Upon interview on 3/21/24 at 1:31 p.m. RN-A stated the facility accommodates planned and unplanned leave of absences, but R1's response was she was not coming back. He denied any knowledge of the facilities attempt to provide a safe discharge. He stated the reason R1's elopement was considered AMA was because she was leaving, not coming back and there were no provider orders. LPN-C was aware that R1 had been asking to leave since 2/29/24. Upon interview on 3/21/24 at 1:55 p.m. the DON stated R1 was her own person, the provider and the team was aware that she was her own decision maker and made her own decisions. She denied any involvement with R1's discharge planning, deferring those questions to social services. She stated there were multiple	21805		

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21805	Continued From page 17 occasions where the staff needed to redirect R1 for smoking in her room. R1 had been given education and policy reviewed. She stated for or a time R1 had her smoking materials with nursing staff so at least she could have the right to smoke. On 3/4/24 a smoke alarm was placed in R1's room. The incident on 2/29/24 started with an unidentified staff member reported they smelled smoke in R1's The DON stated R1 voluntarily allowed the staff to search her room. They found cigarette ends and identified some herbal marijuana the tablets in a plastic bag. She stated the facility attempted "many" interventions with R1. The DON stated the facility intervened by having R1's cigarettes left with nurses, with no restrictions, no limit her access to how many times she could out and smoke. When her privileges were revoked it was for her safety the safety of other residents. She stated the provider offered her nicotine patches; she did not want to quit smoking. She did wear the patches during Covid. R1 had a history of refusing cares. She was her own person, and she had the right to make those decisions. The DON stated she was made aware a resident was upset about the smoking being revoked uncertain of the date. She stated the reason R1 was put on a one-to-one assignment on 3/7/24 was with a goal in mind to observe behaviors from R1 after calling R1 a "bitch" when R1 was begging for cigarettes on the smoking patio from R2 and after the observations they facility would get Associated Clinic of Psychiatry (ACP) involved for immediate interventions. The DON stated she was certain that an LOA was not R1's intention because R1 stated she was leaving and not coming back. She stated R1 was informed if she left and does not take her personal items the facility would store them for 30 days. The DON stated she explained to R1 the facility would not be able to give her	21805		

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21805	Continued From page 18 medications or set-up her services for her. The DON stated the day of 3/7/24 was the first time she heard R1 wanted to leave the facility. The DON stated she was not aware, nor did she order the facility staff to search R1's room. A facility policy titled Resident Rights dated 10/24/23 indicated residents have the right to request, refuse and/or discontinue treatment prescribed by their healthcare provider, as well as care routines outline on the resident's assessment and plan of care. A facility policy titled Smoking and E-Cigarettes revised on 3/9/22 indicated facility will complete an assessment when a resident request to smoking, to determine the level of supervision, assistance, and individualized approaches for safety. In addition, the Smoking Policy outlines the designated areas, notices, education, and requirements for smoking on the facility property to ensure precautions are taken for the resident's individual safety as well as the safety of others in the facility. The facility does indicate revoking a resident's smoking rights. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21805		