Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 2, 2024

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

RE: CCN: 245524
Cycle Start Date: October 3, 2024

Dear Administrator:

On October 15, 2024, we notified you a remedy was imposed. On November 13, 2024 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 November 8, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 30, 2024 be discontinued as of November 8, 2024. (42 CFR 488.417 (b))

In our letter of October 15, 2024, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 3, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 2, 2024

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

Re: Reinspection Results
Event ID: BT9B12

Dear Administrator:

On November 13, 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 October 3, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
October 15, 2024

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

RE: CCN: 245524
Cycle Start Date: October 3, 2024

Dear Administrator:

On October 3, 2024, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 3, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 location for imposition. The CMS location 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 October 30, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 30, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective

October 30, 2024, (42 CFR 488.417 (b)).

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.

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 $12,924; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 3, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Little Sisters Of The Poor is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 3, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.
- 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 "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 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 April 3, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING ______ B. WING ______	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963

(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 10/3/24, 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 H53596229C (MN105145) and H53599121C (MN107022) with a deficiency cited at F695 and F880. 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 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/16/2024

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 695 Continued From page 1

Based on observation, interview and document review the facility failed to ensure a physician order for oxygen was transcribed accurately to ensure adequate monitoring and oxygen administration and further failed to deliver oxygen as ordered for 1 of 1 residents (R5) reviewed for oxygen use.

Findings include:

R5's significant change Minimum Data Set (MDS) dated 8/20/24, indicated R5's cognition was intact, had diagnoses of respiratory failure, obstructive sleep apnea, and had oxygen therapy. MDS did not identify if oxygen therapy was intermittent or continuous.

R5's care plan dated 7/26/24, identified a focus that R5 had oxygen therapy related to obstructive sleep apnea (OSA), 2 liters (L) bled into BIPAP at bedtime. Interventions included: monitor for signs and symptoms of respiratory distress and report to medical doctor (MD) PRN (as needed): respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis (sweating), headaches, lethargy, confusion, atelectasis (collapse of lung that cause shortness of breath), hemoptysis (coughing up blood), cough pleuritic (lining of lung) pain, accessory muscle usage, skin color, and oxygen settings: O2 (oxygen) via Bilevel Positive Airway Pressure (BIPAP) at bedtime, 2 liters bled into continuous positive airway pressure (CPAP).

R5's progress note dated 9/17/24 at 2:06 p.m., R5 was transferred to shower chair, noted to be on oxygen at the time of transfer. After bathing cares oxygen level checked on room air noted to be 82%. Standing House Orders (SHO) for

F 695

1. R5 oxygen order was clarified with provider and updated on 10-3-2024.
2. All residents receiving oxygen have the potential for being affected.
3. All residents receiving Oxygen had their orders reviewed and updated if indicated.
4. Policy and procedure for Oxygen Administration was reviewed.
5. Education for nursing staff on Oxygen Administration and cleaning of O2 equipment policy, specific to Physician initiated Oxygen orders including verification that the physician's order for oxygen includes liter flow, frequency and route and verification that the EMAR in PCC includes monitoring of O2 saturation every shift and weekly change of oxygen tubing, nasal cannula/mask.
6. Oxygen audits on all residents with O2 orders will be completed weekly X 4 weeks, then monthly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the monthly QAA/QAPI Committee for trends and determination of areas of improvement. The next meeting scheduled for 10/31/24 The Committee will provide recommendations if indicated.
7. Responsible party: Director of Nursing or Designee
8. Date of Compliance: 11/8/2024

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F 695

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hypoxia initiated, respiratory assessment completed, SBAR (communication tool) faxed to the provider.

R5's progress note dated 9/18/24 at 4:49 a.m., O2 2L bled into BIPAP, several warm fingers tried with same answer SPO2 = 74% on 2L.

R5's Treatment Administration Record (TAR) dated September 2024, included the order dated 9/17/24, at 2:30 p.m. that directed to initiate and titrate supplemental O2 at 2L per minute (LPM) via nasal cannula (NC) every shift for dyspnea, hypoxia, O2 sats less than 88%, or acute angina (chest pain). If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in the ER.
-Recorded documentation on 9/17/24 at 2:30 p.m. R5's O2 sats were 90%, no oxygen used, and pulse was not recorded.
-Recorded documentation on 9/17/24 at 11:30 p.m. included a chart code of '9' indicating to see progress note. R5's record did not include a corresponding progress note.
-Recorded documentation on 9/18/24 at 6:00 a.m., R5's O2 sats were 90% on 2 LPM and pulse was 77.

R5's record did not specify if oxygen supplementation was continuous or as needed (PRN) and/or how often R5's O2 saturations should be monitored to ensure saturations were over 88% outside of "every shift".

R5's MD order dated 9/18/24 at 11:59 a.m., included an order for oxygen administration however did not identify if oxygen was supposed to be administered continuously or as needed (PRN). The order directed if persistent hypoxia

F 695

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F 695	Continued From page 3	F 695		

(low levels of oxygen in the body) despite 2L nasal canula (NC) oxygen supplementation or if R5 developed tachycardia (pulse of more than 100 beats per minute), or symptoms of somnolence(drowsiness), R5 should be promptly evaluated in the emergency room (ER) given her history of hypercapnia (when carbon dioxide (CO_2) levels in the blood increase above 45), anemia, congestive heart failure (CHF) and high risk for venous thromboembolism (VTA) due to immobility.

R5's TAR included the aforementioned physician order; the order was discontinued on 9/24/24. Recorded entries on 9/22/24 and 9/23/24 at 6:00 a.m., O2 was not used and O2 sats were 90% and 96% respectively. No entries were recorded on 9/22/24 and 9/23/24 for the 2:30 p.m. and 11:30 p.m. shift entries. Between 9/18/24 through 9/24/24, R5's oxygen levels ranged from 89% to 93% on 2 LPM per NC.

R5's advanced practice registered nurse (APRN) recertification visit dated 9/24/24, identified R5 was seen by a provider last week for hypoxia with oxygen levels in the 70's at times overnight and in the early morning. R5 was placed on oxygen on 9/17/24 at 2L per NC which improved her oxygen levels to 94%. R5 was educated on being compliant with her BIPAP. Today nurse reported R5 continued to be on oxygen. Nurse was instructed to get R5 up for breakfast and check O2 saturations. O2 saturations were 87% on room air (RA). New order to continue oxygen 1-2 L to keep O2 above 90% (did not identify if oxygen was to be administered continuously and/or PRN).

R5's transcribed physician orders for oxygen

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F 695	Continued From page 4	F 695		

administration dated 9/24/24, were inconsistent with the direction in the physician note; the order included "Initiate and titrate supplemental O2 at 2 liters per minute via nasal cannula. As needed for with exertion or continuously for SpO2 less than 90% If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in ER. AND every shift for with exertion or continuously for Spo2 less than 90% If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in ER."

R5's TAR included the aforementioned physician order. From 9/25/24 to 9/30/24 R5 was on 2L of oxygen and O2 sats were checked each shift and ranged from 90% to 96%.

R5's progress note dated 9/30/24 at 10:48 a.m., identified R5 was on room air, O2 level checked was 84%, started 2L of supplemental O2, rechecked and currently at 93%.

R5 APRN follow up visit dated 10/1/24 identified R5 had a diagnosis of oxygen dependent and acute and chronic respiratory failure with hypercapnia. No new oxygen orders identified.

R5's TAR dated October 2024 indicated from 10/1/24 to 10/3/24, R5 was on 2L of O2 per NC every shift and oxygen saturations ranged from 91 to 96%.

R5's Kardex dated 10/4/24, identified oxygen with exertion or continuously for SPO2 less than 90%, discontinue if SPO2 is greater than 94%.

During an observation and interview on 10/3/24 at 10:26 a.m., R5 stated when she woke up at 8:45

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a.m. the staff took her CPAP off and never put her oxygen back on. R5 indicated she had been without oxygen for the last two hours and stated, I guess I should put my call light to have someone put it back on me since I can't reach it. R5's oxygen concentrator was running at 1.5 liters and a green hose came from the concentrator that was hooked to the CPAP machine on her bedside table that was out of R5's reach. R5 turned her call light on. R5 stated she was supposed to have her oxygen on at all times and received oxygen through her CPAP at night.

During an observation and interview on 10/3/24 at 10:37 a.m., nursing assistant (NA)-C walked into R5's room to answer the call light. R5 told NA-C that she needed her oxygen put back on. NA-C placed the pulse oximeter on R5's left index finger which read 87%. NA-C turned the oxygen concentrator off and disconnected the green oxygen tubing from the CPAP machine and hooked the nasal canula to the green tubing, handed R5 the nasal cannula, and R5 put it on. NA-C then turned the oxygen concentrator back on. At 10:39 a.m. NA-C checked R5 oxygen saturations again which read 84%. NA-C directed R5 to take some deep breaths through her nose which R5 complied with. At 10:39 a.m. oxygen saturations were checked and read 91%. NA-C stated sometimes staff forget to put R5's oxygen back on and R5 would put the call light on to have the oxygen put on.

During an observation and interview on 10/3/24 at 10:46 a.m., licensed practical nurse (LPN)-B stated she was told that no one put R5's oxygen on this morning and her oxygen levels had dropped to 84%. LPN-B checked R5's oxygen levels which read 96% on 1.5 L of oxygen. LPN-B

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asked R5 how many liters of oxygen she should be on and R5 replied usually 1.5 to 2 liters. LPN-B then turned the rate of flow up to 2 liters and assessed R5's respiratory status. LPN-B stated R5 had no shortness of breath, difficulty breathing, oxygen and pulse was within normal limits. R5 stated she didn't feel any different from when she had the oxygen off. LPN-B stated she thought R5 was supposed to have her oxygen on continuously but would have to look into it.

During an interview on 10/3/24 at 3:04 p.m., registered nurse (RN)-B stated she put the oxygen order in for R5 on 9/24/24. RN-B indicated she had not transcribed the oxygen order as per the physician visit note dated 9/24/24. RN-B stated she had a different understanding of what the doctor said that day and verified she did not call a provider to clarify R5's oxygen orders. RN-B put the orders in per her discussion with the provider and did not fill out a verbal order for the provider to sign.

During an interview on 10/3/24 at 4:24 p.m., director of nursing (DON) stated when a provider puts a new oxygen order in for a resident the nurse transcribing it should enter it as the provider ordered. DON further stated if there were questions about the order the provider would have to be called for clarification. DON indicated R5's oxygen order was entered incorrectly on 9/24/24 and the provider was not notified. DON stated R5 oxygen order should have been to ensure R5 was receiving 1- 2 liters to keep sats above 90%. DON indicated when R5's CPAP was removed in the AM a respiratory assessment should be completed and oxygen orders should be implemented as ordered.

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Facility policy, "Oxygen Administration and cleaning of O2 equipment," revised 9/16/21 identified the purpose was to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues ... Routine if Physician initiated 02 orders. 1. Review physician order for the number of liters and frequency. 2. Gather supplies as above: Concentrator, tubing, nasal cannula and 02 signs. 3. Label MAR for recording 02 sats q shift. 4. Document in nurses notes and notify family.

Facility policy, "Medication and Treatment Orders," dated 12/2017, identified Orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis. 4. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. 5. The signing of orders shall be by signature or a personal computer key. Signature stamps may not be used. 6. The staff and practitioner shall use only approved abbreviations and symbols when ordering and/or charting medications. 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order. 8. Verbal orders must be signed by the prescriber at

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F 695	Continued From page 8 his or her next visit. 9. Orders for medications must include: a.Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.). 10. Only authorized personnel shall call in orders for prescribed medications to the pharmacy. 11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. 12. Orders not specifying the number of doses, or duration of medication, shall be subject to automatic stop orders. a. Drugs not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders. b. One (1) day prior to the date the stop order is to become effective, the nurse supervisor/charge nurse on duty must contact the prescriber or attending physician to determine if the medication is to be continued. 13. Orders for withholding food prior to a test or treatment ("NPO") shall be made by the attending physician as necessary. a. Nursing will use a diet change notification form to inform the food services staff when it is necessary to hold the resident's food tray, and when the tray delivery can resume. b. Nursing staff will review the overall situation for a resident for whom one or more meals is to be held to ensure that any related issues are addressed (e.g., adjustment of insulin doses, maintenance of adequate hydration). 14. Orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring. a.	F 695		

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F 695	Continued From page 9 The attending physician must periodically record in the progress notes the results of the laboratory monitoring and the review for potential complications.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		11/8/24

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F 880	Continued From page 10 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP) were implemented for management of wound care to reduce the risk of infection to others for 1 of 1 resident (R6) who	F 880	1. R6 dressing change was divided into a 2-part procedure on 10-3-2024. One part on AM shift and one part on PM shift to limit amount of time staff are donned in PPE. Coaching was completed with LPN	

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was reviewed for infection control and prevention.

Findings include:

R6's diagnosis list printed on 10/3/24 included; bullous pemphigoid (rare skin condition causing large, fluid filled blisters that appear on the abdomen, chest, upper and lower extremities, groin, and/or axillary region), chronic venous hypertension with ulcer of bilateral lower extremities, non-pressure chronic ulcer of left calf with unspecified severity, non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin, and subacute osteomyelitis of the right ankle and foot.

R6's admission minimum data set (MDS) dated 8/16/24 indicated R6 had a brief interview for mental status (BIMS) of 15 (score of 13-15 indicates individual is cognitively intact), 2 diabetic foot ulcers, and open lesions that required pressure reducing devices in bed, in the chair, application of ointments/medications, application of nonsurgical dressings, and application of dressings to feet.

R6's admission care plan dated 8/9/24 indicated R6 had actual impairment to skin integrity of the left heel, bilateral lower extremities, and groin related to neuropathic diabetic ulcer, venous ulcers, bullous pemphigoid, and moisture-associated skin damage (MASD). Interventions included, encourage good nutrition/hydration and to follow facility protocols for treatment of injury.

R6's active physician orders as of 10/3/24, directed the following wound care treatment:
-Bullous pemphigoid wound care: cleanse with

F 880

A regarding the need for PPE during the entire procedure along with a discussion about barriers to achieve this.
2. All residents on EBP have the potential to be affected.
3. EBP Policy and Procedure was reviewed and revised to include:
• If staff are not tolerating PPE (too warm, etc.) they are encouraged to doff the PPE and take a break from the cares/procedure being performed if safe to do so. Then don clean PPE and resume the cares/procedure.
• When appropriate procedures/cares will be scheduled to be performed in increments less than 60 min.
4. Education for staff on revised EBP Policy and Procedure and donning and doffing of PPE.
5. EBP and PPE audits will be completed daily for 2 weeks (Monday-Friday), then weekly X 4weeks, then monthly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the monthly QAA/QAPI Committee for trends and determination of areas of improvement. The next meeting scheduled for 10/31/24. The Committee will provide recommendations if indicated.
6. Responsible party: Director of Nursing or Designee
7. Date of Compliance: 11/8/2024

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acetic acid, pat dry, apply Clobetasol 0.05% cream to wound bed, apply hydrogel gauze over cream in wound bed and cover with an army battle dressing (ABD-type of gauze to treat large heavy draining wounds) on day shift Monday, Wednesday, and Friday.
-Complete weekly skin inspection progress note for resident skin check. Check skin every Monday evening shift.
-Neuropathic heel wound care: cleanse the area with Vashe wound cleanser, pat dry, apply Iodosorb to the entire wound bed. Do not apply to intact skin, cover with ABD pad with hole cut around the ulcer and cover with another ABD pad. Change daily and as needed. Apply Prevalon boots on day shift.
-Venous ulcers on bilateral legs, cleanse with acetic acid only to wound beds, gently pat dry, apply Aquacel Ag+ ribbon to wound beds only, and cover with ABD and secure with Kerlix on day shift.

R6's provider note dated 9/23/24 indicated R6 has extensive wounds throughout 90 percent of his body, including his back. Wound care was discussed with the facility nurse and facility nurse to apply collagen to his legs, covered with calcium alginate with silver, and secured with absorbent gauze dressing or Opti Lock if obtained. For R6's bilateral hip area, would like to utilize impregnated gauze so these will stay moist and prevent sticking to skin. Wound care is quite extensive and takes 60-120 minutes.

R6's Kardex (reference document that provides a brief overview of each resident) printed on 10/3/24 indicated that R6 is on EBP due to a PEG tube site, bilateral nephrology tubes, and wounds.

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R6's treatment administration record dated 10/1/24-10/31/24 identified R6's wound care was completed per provider orders.

During observation on 10/3/24 at 10:51 a.m., upon entrance to R6's room, there was an orange sign taped to the wall with two stop sign icons in the top right and left corner of the sign. The sign indicated Enhanced Barrier Precautions, everyone must: clean their hands, including before entering and when leaving the room. Providers and Staff must also: wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, and tracheostomy. Wound care: any skin opening requiring a dressing. Upon entering R6's room, licensed practical nurse (LPN)-A was in the process of changing R6's left lower extremity dressings. LPN-A applied Vaseline, ABD pads, and a compression wrap to R6's left lower extremity per the wound care orders. LPN-A was not wearing a gown as directed by the EBP sign outside R6's door and the facilities infection prevention policy, only gloves were worn.

On 10/3/24 at 2:58 p.m., nursing assistant (NA)-A stated appropriate indications when staff are to use personal protectice equipment (PPE) and the donning/doffing process for using PPE. NA-A stated the order of donning PPE starting with the mask, gown, then gloves. NA-A stated PPE is donned before entering and doffed in the room before exiting. Hands to be washed before entering and after exiting the room.

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10/3/24 at 3:00 p.m., NA-A stated training was done by in-services and online education. Once completed, staff were to sign a paper document that indicated the content was reviewed.

During interview on 10/3/24 at 12:43 p.m., LPN-A stated the gown was removed while providing care to R6 since it "got hot" in R6's room. Further, LPN-A stated EBP precautions were in place to prevent the spread of infection. LPN-A discussed how to don and doff PPE appropriately and stated EBP training was completed online. LPN-A indicated that a resident on EBP would have a sign outside their door and an isolation cart with PPE outside the resident's room indicating the necessary precautions.

During interview on 10/3/24 at 1:16 p.m., registered nurse (RN)-A stated staff received EBP and TBP training at the time of hire by online education, Educare (education platform), and facility/staff meetings/in-services. RN-A indicated that the most recent EBP content was provided to staff after the 2024 recertification survey as part of the plan of correction (POC) that was approved. RN-A also stated in some situations on the spot training for staff was completed.

On 10/3/24 at 1:21 p.m., RN-A stated staff were expected to be able to know why EBP was in place for any resident, be aware of the signage for EBP, and how to don and doff PPE appropriately.

On 10/3/24 at 4:29 p.m., DON stated staff were made aware of residents on EBP with signage on or near the resident's door, PPE cart, and the Kardex. DON stated staff were expected to wear gowns, gloves, masks, and eye protection if

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necessary. DON also stated the purpose of EBP and expected staff to follow the policy.

Facility policy named Infection Control Transmission/Isolation Precautions revised on 3/2024 indicated: Enhanced Barrier Isolation Precautions: Example; Multidrug-Resistant Organisms (MDRO), Methicillin-resistant staphylococcus aureus (MRSA) Vancomycin-resistant Enterococcus (VRE) Carbapenem-resistant Enterobacteriaceae (CRE).

Enhanced Barrier Precautions expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Face protection may also be needed if performing activity with risk of splash or spray.

Enhanced Barrier Precautions apply to residents with any of the following:
- Infection or colonization with a novel or targeted MDRO when Contact Precautions do not apply.
- Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. Wounds include chronic wounds, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing, do not require EBP.

Examples of high-contact resident care activities requiring gown and glove use for Enhanced

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Barrier Precautions include:
Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing.

Gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 15, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: BT9B11

Dear Administrator:

The above facility was surveyed on September 25, 2024 through October 3, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00763	A. BUILDING: ______ B. WING ______	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR	330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 9/25/24, 9/26/24, 9/27/24, 9/30/24, 10/1/24, 10/2/24, and 10/3/24 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 orders were issued. Please indicate in your electronic	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 10/23/24

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2 000	Continued From page 1 plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H55248702C (MN106878) with licensing orders issued at 0190, 0830, 0285. 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 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	2 000		

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2 000	Continued From page 2 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		
2 190	MN Rule 4658.0060 B. Responsibilities of Administrator; policies The administrator is responsible for the: B. formulation of written policies, procedures, and programs for operation, management, and maintenance of the nursing home; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility's governing body failed to establish and implement policies regarding the management and operation of the facility and further failed to ensure the administrator reported to and was held accountable to the governing body. This had to effect all current and future residents residing in the facility. Findings include: Policies: During a review of facility policies, the facility was unable to provide a copy of numerous requested policies which included: policy on physician visits, including frequency; policy on emergency physician care; policy on physician delegation of tasks; policy on physician delegation of dietary orders; policy on governing body; policy on communication between administrator and	2 190	corrected	11/8/24

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2 190	Continued From page 3	2 190		

governing body; policy on administration accountability to governing body; policy on staff licensure verification.

Policies provided after requested by surveyors dated after the survey began included: Policy Regarding the Governing Body, Administration Appointment and Accountability to the Governing Body dated 9/28/24; Policy Regarding the Communication of the Appointment of the Administrator and Director of Nursing to MSN [sic, State Agency] dated 9/28/24; Schedule of Physician Visits dated 9/30/24; Policy on Staffing dated 9/30/24, License Verification dated 9/28/24.

The Facility Assessment with dates of assessment 1/29/24 to 2/1/24, included a section titled "Describe the evaluation process for policies and procedures to ensure that all employees meet current professional standards and practice" which noted the following: "Our policies and procedures reflect resident needs as well as regulations, rules and laws demanded by the government. Our policies and procedures are reviewed annually and as needed depending on resident needs, new technology, a change in professional standards of practice, as well as a change in the physical plant or environmental hazards."

Facility document titled Job Description for the administrator role dated 6/9/91, had an Essential Duties section which included "administers, coordinates, and directs all activities of the nursing home, including, but not limited to establishing policies/procedures/programs ... Responsible to establish and enforce all facility, departmental, personnel, and resident care policies and procedures in accordance with accrediting agency requirements, standards of

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2 190	Continued From page 4	2 190		

practice and the core philosophy of [the organization] ... Monitor changes in state/federal regulatory standards and long term care trends and implement new policies as needed."

During an interview on 9/30/24 at 3:50 p.m. with the stand-in for the chief executive officer (SCEO), contracted registered nurse (CRN)-A, and the director of nursing (DON), facility policies were reviewed. SCEO stated physician visits are conducted in accordance with regulation, but "we just do it, we don't have a policy." The DON stated, "I have not seen a policy on emergency physician care." The SCEO, CRN-A, and DON confirmed they were not aware of a policy regarding physician delegation of tasks and the DON stated, "I haven't seen a policy that physicians can delegate dietary orders." SCEO noted the governing body consisted of administrator-A as the president, the assistant to the administrator (AA) as the vice president, and CRN-B as the secretary treasurer and they meet annually but was not able to provide any facility policies dated prior to the survey regarding the governing body.

During an interview on 10/1/24 at 1:31 p.m., administrator-A stated the governing body was responsible for establishing and implementing policies regarding the management and operation of the facility. Administrator-A stated the Quality Assurance and Performance Improvement team discussed policies at their meeting and they also had consultants for the region who would provide generalized policies that the facility then personalized. Administrator-A noted policies were available electronically on the internal organizational website for their region and quite a few policies and forms had been standardized on the regional level.

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2 190	Continued From page 5	2 190		

Administrator:
The Facility Assessment with dates of assessment 1/29/24 to 2/1/24, identified the facility's governing board members as the administrator-A, AA and CRN-B. Administrator-A was also identified as the current administrator and chief executive officer.

Facility document titled Organizational Chart dated 9/14/24, identified the "Mother Superior" as the chief executive officer (CEO) of the organization to whom the administrator reported.

Facility document titled Job Description for the administrator role dated 6/9/91, included "Reports to: Governing Board." The Essential Duties section included "Maintain ongoing communication between the facility governing body, supervisors and employees through routine meetings and periodic reports."

Facility policy titled Policy Regarding the Governing Body, Administration Appointment, and Accountability to the Governing Body dated 9/28/24, was created and provided to surveyors after entrance. The policy included "The [organization members] at [the facility] are governed on a local level by an appointed Mother Superior. She is responsible to a Provincial Superior and her council ... The [facility's] Organizational Chart clearly shows that the administrator is directly responsible to the Mother Superior."

During an interview on 9/30/24 at 3:50 p.m., regional consultant (RC) stated the governing body functions with the three members (administrator-A, AA, and CRN-B) making decisions, "but the Mother Superior

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2 190	Continued From page 6	2 190		

[administrator-A] is the final word and then the provincial Mother Superior and on up." The RC stated the provincial Mother Superior "is over a group of homes for the sisters [facility's staff in clergy roles], not the residents or employees, but the sisters and the way we operate the homes."

During a phone interview on 10/1/24 at 1:31 p.m., administrator-A stated the governing body had not discussed policies regarding the governing board and stated she would agree they were not addressing and not following the recommendations for the governing board. Administrator-A identified herself as the administrator, Mother Superior of the facility, and president of the governing board and stated she was held accountable to her regional director, the regional Mother Superior, who provided oversight of all the homes in the region. Administrator-A was not able to articulate how she, as the administrator, was held accountable and reported to the governing body of which she was president or how she, as the administrator, reported to the Mother Superior of the facility when she occupied both roles. She stated, "We do the best we can, we are subject to the regulations, do our best with survey, and do our best with the regulations that are subject to long term care. We are in the process of hiring a lay [non-clergy] administrator. In most of our [the organization's] homes we are separating that function out because it was for many years that the governing body was the administrator also."

During an interview on 10/1/24 at 2:12 p.m. with AA and CRN-B they confirmed they were the other members of the facility's governing body in addition to administrator-A. AA stated in the organization's homes the Mother Superior is usually the president of the governing board and

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2 190	Continued From page 7	2 190		

Continued From page 7

in many homes they are trying to now have lay administrators because "the Mother Superior and administrator are two different functions." AA noted that for administrator-A to report to the board, the three of them would meet and administrator-A "would give us the update on things that were happening and that was basically all I can say. We would meet at the end of the day every day and go through what happened that day, informally." CRN-B stated the "oversight for the administrator would be both of us and we would assure that she is doing the correct thing. And like [administrator-A] said, we are religious and we are held accountable, we are truthful and see each other and what is going on." AA stated, "the oversight is really provincial [regional-level] ... Mother reports to provincial if anything major goes on with the home or there is a problem with anything." AA further stated administrator-A is "basically accountable to her [the provincial Mother Superior's] council or her [administrator-A's] team, me and [CRN-B]." AA and CRN-B were unable to further articulate how administrator-A was held accountable to and reported to the governing body when administrator-A was also CEO and president of the governing body.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could review/revise policies and procedures on administration responsibility. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff are appropraiatly trained and report these findings to their QAPI

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2 190	Continued From page 8 committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 190		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure completion of 12 hours of annual in-service training for 2 of 5 nursing assistants (NA-F, NA-G) reviewed for annual training. Additionally, 1 of 5 nursing assistants had no abuse or dementia training which had the potential to affect all 36 residents in the facility. Findings include: During interview on 10/2/24 a 4:19 p.m., NA-F was unaware of how many hours of required	2 285	corrected	11/8/24

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2 285	Continued From page 9	2 285		

training was provided but thought required training had been completed.

Upon review of NA-F's employee file NA-F did not have 12 hours of employee training.

During interview on 10/2/24 at 4:24 p.m. NA-G reported completed online Relias throughout the year. Outside of Relias training NA-G stated the director of nursing (DON) would compose a letter for all staff to sign every three to four months. NA-G reported recalled an incident which happened last year and received dementia training from signing off on a letter.

Upon review of NA-G's employee file NA-G had not received 12 hours of annual training or required abuse dementia training.

During interview on 10/2/24 at 2:35 p.m., DON and human resources manager HR-A, reported not being able to identify 12 hours of Inservice training for NA-F or NA-G from Relias or in employee files. DON confirmed NA-G did not have abuse or dementia training completed and should have.

Training plans requested not received.

Facility assessment dated January 29th 2024 through February 1st 2024, identified the facility insists staff were expected to be trained with necessary skills to care for the elderly because the staff were the facilities extended hands. Each person hired by the facility were to be determined competent to provide essential services to residents based on self-knowledge, completion of training/competency and licensure or certification. Each job description was to identify the required education and credentials for the job, Staff

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2 285	Continued From page 10 education and credentials were to have been verified before being hired and checked, at least yearly. Form titled "little sisters of the poor job description" for "certified nursing assistant undated, identified all certified nursing assistants must attend in-services as mandated by local state/federal regulations and to attend department or unit meetings. Core Competencies identified human dignity logical thinking and ethical integrity and ability to prioritize work demands. Nursing assistant job description did not identify abuse or dementia training. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on training/nurse aid performance reviews. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff are appropraiatly trained and have performance reviewed yearly, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 285		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		11/8/24

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2 830	Continued From page 11	2 830		

custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.

This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to identify, comprehensively assess, implement individualized interventions for wandering, exit seeking behaviors, and elopement for 2 of 2 residents (R1, R2) who had a history of repeated exit seeking behaviors. The facility's failures resulted in immediate jeopardy (IJ) when R1 eloped from the facility, was found on a city street, and returned by a passerby.

corrected

The immediate jeopardy began on 9/5/24 after R1 attempted elopement multiple times, the facility failed to complete comprehensive wandering/elopement assessments, monitoring system, and appropriate intervention resulting in R1's actual elopement on 9/21/24. The immediate jeopardy was identified on 9/26/24 and the chief executive officer and director of nursing (DON) were notified of the immediate jeopardy on 9/26/24 at 6:18 p.m. The immediate jeopardy was removed on 10/3/24 at 11:11 a.m., but noncompliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

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2 830	Continued From page 12	2 830		

Findings include

R1's significant change Minimum Data Set (MDS) dated 4/4/24, indicated R1 had diagnoses that included Alzheimer's disease and had severe cognitive impairment. R1 did not have wondering behaviors.

R1's progress note dated 4/3/24, indicated R1 was found walking to the elevator without shoes on, staff attempted to redirect, he became agitated, and upon reapproach was successfully walked back to his room. The note did not specify if R1 had been exit seeking and/or wandering.

R1's Fall Risk Assessment dated 6/21/24, contained a mental status section. The "wanders" box was selected with a checkmark with no other information identified.

R1's quarterly MDS dated 6/27/24, indicated R1 did not have wondering behaviors even though the fall risk assessment dated 6/21/24 identified R1 wanders. The MDS indicated R1 was independent using a walker with ambulation of distances of 10 feet and required staff supervision/cues for distances of 50 to 100 feet.

R1's record reviewed between 4/3/24 and 9/5/24, identified although progress notes identified a history of wandering behaviors the record did not include a comprehensive assessment of the wandering to identify trends/patterns and causal factors. Additionally, the record did not include a comprehensive elopement risk assessment. Further R1's care plan did not address R1's wandering and R1's risk for elopement until 9/11/24.

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R1's progress note dated 8/5/24, indicated R1 was yelling in the hallway and wanted to go in another resident's room and was successfully redirected by staff.

R1's progress note dated 8/30/24, indicated R1 was observed ambulating in the hallway in his socks and underwear and "redirection took several attempts before resident was agreeable to return to his room."

R1's progress note dated 9/5/24 at 6:58 a.m., indicated R1 was wandering the hallway in socks and boxers without his walker and was effectively redirected by staff.

R1's progress note dated 9/5/24 at 11:15 a.m., indicated R2 made multiple attempts to exit the front door of the facility pushing his walker into the door at least six to seven times. Several initial staff attempts at redirection were unsuccessful but activity assistance staff walked with him outside and then convinced him to return to his room and "get [R1] back into the facility safely."

R1's progress note dated 9/5/24 at 3:51 p.m., indicated "resident wandered today and was resistant to staff to return to his room." A family member was called, and this helped the resident.

R1's progress note dated 9/5/24 at 3:53 p.m., indicated "resident wandered down to main floor and was going outdoors."

R1's Fall Risk Assessment dated 9/6/24, identified R1 wandered, but lacked further information about his wandering behaviors or elopement risk.

During an interview on 9/26/24 at 10:20 a.m.,

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director of nursing (DON) stated the facility had an elopement assessment that nursing staff are supposed to complete on admission. The assessment should also be done if residents have "a change in condition like exit-seeking" or "if they elope, or if they show a risk." DON expected nurses to document behaviors like wandering or exit-seeking in a progress note. When residents were identified to have wandering behaviors, staff should complete 30-minute safety checks to determine the resident's where abouts and safety. The DON identified the safety risks associated with elopement was high, especially for residents who were confused or lack proper clothing or awareness. Residents who eloped are at risk for getting sick, seriously injured, hit by a car, exposed to weather, and confused residents were at serious risk for getting lost in the community. DON stated an awareness of R1's elopement attempt on 9/5/24 and noted "on that day it became very evident he was very high risk for elopement." The DON expected an elopement assessment to have been completed at that time with interventions put in place like 30-minute checks.

R1's quarterly MDS assessment dated 9/11/24, indicated R1 had wandering behaviors on one-to-three of the seven-day assessment period, used a walker independently, and did not use a wander/elopement alarm. The impact of wandering section "does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g. stairs, outside of the facility)" question was left blank.

Even though R1's MDS assessment dated 9/11/24 identified R1 had wandering behaviors, R1's record did not include a comprehensive

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assessment of R1's wandering/exit seeking behaviors that would identify R1's mannerisms, precursors, or behaviors for determination and implementation of individualized interventions for management of wandering/exit seeking behaviors.

R1's care plan was not revised until six (6) days after R1 displayed exit seeking behaviors and did not address target behaviors associated with wandering/exit seeking. The care plan included a behavior focus initiated on 9/11/24 that identified R1 was an elopement risk/wanderer with a history of attempts to leave the facility unattended and impaired safety awareness. Interventions dated 9/11/24 included:
- Assess for fall risk
- Distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book
-"Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate"
-Monitor for fatigue and weight loss

R1's progress note dated 9/18/24, indicated R1's primary provider, Doctor of Medicine (MD)-A, visited the previous day and "was updated on attempted on [sic] behavior, increased confusion, and elopement risk (9/5/24)." In review of R1's record, it could not be determined what R1's level of risk of elopement was as a result of the R1's "increased confusion" on 9/18/24 and not evident R1's care plan was revised.

R1's progress note dated 9/21/24 at 3:44 p.m., indicated R1 took a nap and was disoriented upon waking, "looking for his wife." Staff "tried to redirect resident showing him pictures of his

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family, but it did not work."

R1's progress note dated 9/21/24 at 8:30 p.m., indicated R1 "went down in the elevator by himself and passed through front door and went outside during dinner time." R1 had refused to come to dinner three times, when staff went to his room after dinner, they found he was missing. Staff conducted a search. A visitor found R1 on a street in the neighborhood and returned him home to the facility. R1 was assessed and appeared stable with no new injuries noted. Family and the on-call physician were notified.

R1's progress note dated 9/21/24 at 8:59 a.m. [sic] indicated contracted registered nurse (CRN)-A was notified by staff that R1 was not on his unit, a full house search was completed, and R1 was located by a visitor on a street in the neighborhood. R1 returned home to the facility with the visitor, did not appear to have any injuries, was started on safety checks every 30 minutes, and the medical director and on-call physician as well as family were notified.

R1's first recorded Elopement Risk Evaluation dated 9/21/24 at 11:22 p.m. identified R1 had a history of attempting to leave the facility without informing staff, wandered, had wandering behavior that was a pattern or goal-directed, and the wandering behavior was likely to affect the privacy of others. The evaluation identified R1 had not verbally expressed the desire to go home/packed belongings/or stayed near an exit door, did not wander aimlessly or in non-goal-directed fashion, and was not admitted or re-admitted within the past 30 days with lack of acceptance of the situation. The two sections of the assessment with spaces to enter cognitive evaluation scores were blank. The question "does

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the resident have a history of elopement or an attempted elopement while at home" was marked no which was not accurate according to progress notes dated 9/5/24 and 9/21/24. The question "Is the resident's wandering behavior likely to affect the safety or well-being of self/others" was marked no which was not accurate according to progress notes dated 4/3/24 to 9/21/24 when R1 repeatedly demonstrated wandering behaviors while improperly dressed, attempted to elope once, and successfully eloped once.

A facility Elopement Incident Report dated 9/21/24, noted R1's elopement on 9/21/24 and the corresponding progress note. It further indicated R1 was oriented to person only, had no pre-disposing environmental factors, had predisposing physiological factors including confused and impaired memory, and had "none of the above" selected from a list of predisposing situation factors. Facility records of R1's elopement lacked a comprehensive causal analysis for the probable root cause that led to R1's elopement for the determination of appropriate interventions to prevent re-occurrence of elopement.

R1's physician orders included an order dated 9/21/24 at 11:30 p.m., "resident is on 30 minutes safety check every shift." However, review of R1's record did not include an assessment that corresponded with the determination of 30-minute safety checks. During an interview on 9/26/24 at 10:20 a.m. DON was not able to identify how R1 was comprehensively assessed to determine 30-minute checks were an appropriate intervention for R1, how R1's needed level of supervision was determined, or how R1's known specific wandering behaviors were monitored. Regarding a root cause analysis of R1's

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elopement, the DON stated, "we have talked about in our IDT [inter-disciplinary team] meeting but haven't sat down to do it."

R1's care plan was not revised until 2 days after the incident and did not include target behaviors and interventions associated with wandering/exit seeking. R1's care plan for functional abilities and mobility included an intervention initiated on 9/23/24, "[R1] is able to walk independent[ly] with walker but needs assist and cues to specific destination, particularly longer walks as he will wander and get lost specially if he gets on the elevator."
R1's care plan for behavior included an intervention initiated on 9/23/24:
- Safety checks every 30 minutes
- Report immediately to the nurse if resident is not on the unit
- Photo at the reception desk.
R1's care plan for behavior included interventions initiated on 9/24/24 that included:
- Notify nurse if resident starts exhibiting exit seeking behaviors
- Redirect resident if he is wandering.

Review of R1's 30-minute safety checks documented on paper between 9/21/24 through 9/25/24 identified they were completed by staff member's initials and/or by initials with R1's location inside the facility. No other information pertaining to the checks was documented. Additionally, record did not identify and/or include a monitoring system and/or evaluation for of any wandering behavioral patterns or trends as directed by the care plan dated 9/11/24.

During a return phone call interview on 9/27/24 at 3:09 p.m., security officer (SO)-A stated he worked on 9/21/24 and saw R1 go outside for

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2 830	Continued From page 19 some fresh air between 6:30 and 7:30 p.m. SO-A was then notified R1 was missing, and he was returned to the facility by visitors. When SO-A asked R1 where he had been going, R1 responded, "I was going home." SO-A stated he was not aware at the time that R1 was an elopement risk. SO-A noted he was aware now because R1's photograph had been placed at the front desk and he had received training to redirect R1 or other residents at risk of elopement away from the front door but did not articulate targeted interventions specific to R1's known behaviors. During an interview on 9/26/24 at 11:33 a.m., contracted registered nurse (CRN)-A stated she was working on 9/21/24 when R1 eloped. CRN-A stated it was around 6:00 p.m. when R1 was noted missing, and they conducted a full house search. A visitor who had been at the facility for a community event located R1 a few blocks away from the facility "on the corner of North Smith Ave. and 7th street." CRN-A explained that was a busy intersection, the visitor found R1 on the corner and visitor reported R1 had been afraid to cross the street. R1 was then returned to the facility with the visitor in the personal vehicle at approximately 6:40 p.m. CRN-A noted R1 was placed on 30-minute safety checks upon his return and found to be unharmed. CRN-A identified R1 was not safe alone in the community and was at risk of eloping. CRN-A stated R1 had left the facility because he was looking for his wife and stated she did not have a "good answer" to how 30-minute checks addressed this behavior except that staff "engage him, listen to him." CRN-A noted she might have put him on 15-minute checks, but she knew he was so tired when he returned that he was safe being on 30-minute checks. She further stated she "ordinarily" would do assessments, find out what	2 830		

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activities he likes, what interventions are on his care plan, find out what had been done in the past, and determine what he liked and disliked. CRN-A explained, 30-minute checks seemed to have been what "the standard" has been at the facility for other residents with behaviors. "That's been what they've [facility staff] done ... it is just what they've been doing in the facility and that's why they went with 30." She confirmed that she completed an elopement assessment when R1 returned the evening of 9/21/24, it should have been done prior, "I was shocked when I didn't find more elopement assessments on him"

During an interview on 9/26/24 at 3:43 p.m., nursing assistant (NA)-A reported she was the nursing assistant for R1 on 9/21/24 starting at 2:30 p.m. At approximately 2:40 p.m. R1 was in the common area with no pants on looking for his wife and NA-A redirected R1 to his room. NA-A noted she saw R1 exit-seeking and wandering without pants on looking for his wife a second time around dinner and redirected R1 to his room and left him there alone. NA-A then joined LPN-A in the dining room to assist with dinner and stated she did not report these behaviors to the nurse, licensed practical nurse (LPN)-A. NA-A was notified after dinner by LPN-A that R1 was missing. NA-A was aware of R1's continued confusion and desire to leave the unit on 9/21/24 but was not aware of additional interventions.

During an interview on 9/25/24 at 1:26 p.m., nursing assistant (NA)-C stated R1 seemed to be declining and "he just wanders". R1 wanders or try to go down the elevator when he was looking for his wife, thought it was mealtime, or wanted to go to church. NA-C explained staff check on R1 every 30 minutes; checks were documented by initially next to times on a printed paper. NA-C did

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not indicate any further information was expected to be documented such as what R1 was doing or where he was at the time the check was performed. NA-C stated she had checked on him that morning (9/25/24) at 10:30 a.m., and then went in another room. NA-C stated she "wasn't even in there 15 minutes and [R1] had already gone down the hall and to the elevator ... he's just that quick." NA-C stated to know who wanders she would ask in report and check the care sheets NA's use. NA-C stated she wished they had a wandering alarm system but was not sure what else to do except "just be really diligent about keeping an eye on [R1]." NA-C stated it was "definitely not safe" for R1 to go out the front door or outside the facility alone and was aware he had eloped from the facility the previous weekend.

During an interview on 9/26/24 at 7:44 a.m., NA-B reported R1 had wandering tendencies, and it was common for R1 to wander while inappropriately dressed, more commonly in the evening. NA-B recalled a time R1 was in his underwear and socks by the elevator looking for something and she redirected R1 to his room. NA-B reported R1 sometimes left the unit on his own, and she would follow R1 if he was agitated. NA-B stated she had concerns about R1 attempting to leave the building independently. NA-B stated some residents had specific charting to complete regarding if behaviors were present, but R1's behavior charting was only as needed.

During an interview on 9/25/24 at 4:00 p.m., licensed practical nurse (LPN)-A stated currently R1 had some confusion, but stated R1 was not at risk for elopement, did not have wandering behaviors, and was not aware of the previous elopement attempt on 9/5/24. However, LPN-A

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2 830	Continued From page 22 stated he worked on 9/21/24 when R1 eloped from the facility and was returned by a visitor; LPN-A was not aware of who the visitor was. LPN-A recalled the shift he worked on 9/21/24, he was not made aware of any earlier behaviors that had occurred that day. LPN-A stated earlier during his shift R1 had attempted to go down to church and was redirected. LPN-A did not endorse R1 attempting to go to church as wandering behavior, noted this was a typical behavior, and did not communicate to nursing assistants (NA) of R1's attempts. After dinner LPN-A went to check on R1 and noted him missing. After R1 returned LPN-A assessed R1 and noted no injuries. LPN-A stated he told the aides what happened and to prevent it from happening again, the intervention was "checking him every 30 minutes" but did not identify any specific behavior monitoring that was put into place. LPN-A was not able to articulate how residents were assessed for elopement risk and thought nursing leadership would follow-up on a need for increased elopement risk for R1. LPN-A identified currently it was "okay" for R1 to walk around the facility by himself because "he doesn't go far." LPN-A articulated since R1's elopement on 9/21/24, current safety interventions were 30-minute checks and having a photograph of R1 at the front desk. He did not identify targeted behavior monitoring or interventions in place related to R1's known wandering behaviors, tendency to look for his family, and desire to go to church. During an interview on 9/26/24 at 7:43 a.m., LPN-C stated she was not aware of an "official assessment" for elopement. LPN-C stated she determined elopement risk by assessing cognitive status, ability, mobility, how alert residents were to their environment, and went from there. LPN-C	2 830		

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stated, "you just get to know your residents" and "you just inform staff to be mindful and keep an eye on them." LPN-C stated she would consult a resident's care plan to identify their wandering behaviors and it should note what staff are doing to decrease the changes of the resident leaving the facility or the unit.

During an interview on 9/26/24 at 7:55 a.m., LPN-D stated to her knowledge there was no formal elopement assessment done for residents, but she thought it would be a good idea to have them. LPN-D noted staff would know if someone was an elopement risk or had wandering behaviors by "knowing your residents." LPN-D stated she would check care plans for interventions related to wandering behaviors because "behaviors can be very specific."

During an interview on 9/26/24 at 1:53 p.m. DON and registered nurse (RN)-A, the DON confirmed the assessment completed on 9/21/24 was not accurate or complete. DON noted she would consider R1's wandering behavior likely to affect the safety or well-being of himself or others, though the assessment identified this was not likely. RN-A stated she was the MDS RN and had never completed elopement assessments, "no one in this building has had an elopement assessment done." The DON stated R1 was not able to safely be out in the community independently. The DON stated she assessed R1's needed level of supervision by "looking at his behaviors." DON was not able to further articulate how this assessment process worked, "I don't know about the process. If residents require monitoring related to behaviors or falls, historically the nurses "automatically" implement 30-minute safety checks. DON stated there was no monitoring for R1's wandering behaviors in

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place prior to the survey. The DON stated she would expect updated interventions to be added to a care plan on the same day as an attempted elopement. She confirmed after R1's attempted elopement on 9/5/24 his care plan was not updated until 9/11/24. RN-A noted R1 later eloped on 9/21/24 and his care plan was not updated until 9/23/24 when 30-minute safety checks were added. RN-A confirmed R1's need to be escorted by staff when leaving the unit was not added to his care plan until after surveyors were on site. RN-A further noted that if specific wandering behaviors were not noted on care plans, staff would not know how to manage the behaviors. The DON was not able to identify how the interventions added to R1's care plan related to elopement risk were determined to be individualized, comprehensive, or effective in the absence of a comprehensive elopement risk assessment and behavior monitoring.

During an interview on 9/26/24 at 3:49 p.m., MD-A stated she was aware R1 had eloped. MD-A identified R1 was not safe to be independent in the community and had dementia and a poor cognitive status. MD-A stated R1 was "definitely" an elopement risk with a history of wandering behaviors. If he eloped, MD-A stated she would be worried about R1 getting lost, falling, or getting hurt and worried about vehicles in the area, people in the downtown community, and cold or weather exposure. MD-A would expect elopement assessments to have been completed, immediate interventions to be implemented, behaviors to be monitored and documented, in addition to strategies to be in place to minimize the risk of further elopements.

During an interview on 10/2/24 at 3:49 p.m., the facility's medical director stated he was aware of

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LITTLE SISTERS OF THE POOR	**330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102**

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R1's elopement on 9/21/24. The medical director noted he would expect close monitoring of residents at risk for elopement, including close assessment of wandering behaviors and care planning. The medical director noted residents should be assessed to determine their elopement risk level including day to day behaviors, history, physical, risks such as dementia, and behavior management on admission and periodically. The medical director identified residents with dementia who are at increased risk of elopement as requiring increased monitoring from staff based on their behaviors. The medical director noted someone with a history or dementia and wandering "should not be leaving the floor and they should not be leaving the facility ... they should be escorted." The medical director stated a resident exhibiting behaviors like wandering in the hallway could be a risk to themselves or others and if they exited the facility could be at risk of getting lost, falling, getting injured due to weather conditions, getting in an accident, and identified the risk as "quite high" for the facility's location in downtown St. Paul and proximity to busy streets.

R2

R2's MDS dated 9/4/24, identified R2 had severely impaired cognition and diagnoses including Alzheimer's disease with late onset and non-Alzheimer's dementia. R2 was ambulatory with substantial assistance from staff and utilized a walker.

R2's Activity Assessment/Engagement Profile dated 6/19/24 identified R2 was able to make basic decisions, had a short attention span and did not follow directions. R2 was not identified as having precautions in place for fall prevention and

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2 830	Continued From page 26 elopement. R2's progress note dated 8/29/24, identified R2 came out of her room agitated and worried while calling out loudly several times, "where is Patrick?" The writer discovered "Patrick" was a six-year-old child that the resident was "babysitting". Staff informed resident the child was safe at home with his mother and the mom was very appreciative of help. R2's fall risk assessment dated 8/29/24, identified R2 was disoriented, but the pre-populated wandering and intermittent confusion behaviors were not selected. R2's progress note dated 9/6/24 identified R2 attempted to get on an elevator going down which had a staff member in it. Staff attempted to distract R2, but she was determined to get back on and go to her old home stating, "I just came yesterday, and I want to see my dog, we live next door." R2 and staff went down to the first floor and R2 did not recognize the area. R2 returned to her room with the assist of a second staff member but did not remain in her room. Staff assisted R2 to go downstairs again and helped R2 walk outside in the enclosed back garden for a few minutes. Staff then returned R2 to the unit who sat outside the nurses' station calmly. R2's progress note dated 9/6/24, identified R2 was crying on the phone with a family member (FM)-A stating she wanted to go home. FM-A was able to de-escalate. R2's record did not include a comprehensive elopement assessment nor an assessment that identified individualized target behaviors and interventions associated with wandering/exit	2 830		

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seeking. Further, R2's record did not identify implementation of immediate interventions after R2's exit seeking behaviors on 9/6/24 and the care plan was not revised until 9/12/24, six (6) days after the incident.

R2's care plan included a focus on behavior initiated on 9/12/24 identifying R2 was an elopement risk/wanderer as evidenced by history of attempts to leave facility unattended, impaired safety awareness, hearing and vision loss and intermittent confusion. Interventions dated 9/12/24 included:
- Assess for fall risk
- Disguise exits: cover doorknobs and handles, tape floor
- Distract R2 from wandering by offering pleasant diversions, structured activities, food, conversations, television, and books
- Identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.
- Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.

R2's record did not include an evaluation of R2's pattern of wandering and associated behaviors to ascertain effectiveness of interventions.

During an interview on 10/3/24 at 8:51 a.m., NA-B reported she was aware of R2's wandering and R2 typically wandered in the evening and overnight. NA-B noted R2 would wander looking for food, but not necessarily leave the unit. NA-B stated there was a time R2 was looking for her dog and attempted to leave the floor on day shift. NA-B described R2 as confused and unable to make her basic needs met independently. NA-B

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stated she had not documented these previously observed wandering behaviors and just let the nurse know when and if she was having them. NA-B noted she would know if someone was an elopement risk by seeing if they tried to leave the unit.

During an interview on 9/25/24 at 11:47 p.m., LPN-B stated sheets of printer paper were taped over the elevator buttons as a distraction for residents that staff did not want getting on the elevator alone. LPN-B identified R2 was a resident she did not want on the elevator by herself because she had been told by another staff member that R2 had a history of confusion and had previously tried to get on the elevator.

During an interview on 9/26/24 at 9:12 p.m., LPN-C reported R2 had wandering behaviors, typically slept all day, would get up between 5:00 p.m. and 6:00 p.m. and wandered around the unit. LPN-C reported R2 had her picture by the front desk, which was generally something done for people at risk of leaving the building. LPN-C reported she thought this was sensible due to the risk of R2 wanting to leave and the risk of her leaving at night.

During an interview on 10/3/24 at 8:44 a.m., family member (FM)-A stated she was aware R2 had been looking for her dog on 9/6/24 and noted "I know she [R2] wants to come home." FM-A stated R2 should not leave the facility on her own and would not know how to get back.

During an interview on 9/26/24 at 1:53 p.m., the DON and RN-A both stated R2 had a known tendency to look for her dog who died a long time ago. The DON stated there are days where R2 gets up and looks for her dog, she walks from her

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2 830	Continued From page 29 room to the dining room and reported an incident where R2 was looking for her dog on 9/6/24. RN-A stated R2 had gone down to the first floor on 9/6/24 and attempted to leave the facility. RN-A reported no elopement assessment had been completed and confirmed R2's care plan was not updated until 9/12/24. RN-A further confirmed R2's record did not contain any elopement assessments and no elopement assessment had been completed. The DON stated she would expect an immediate intervention to be added and for R2's care plan to have been updated and an elopement assessment completed on 9/6/24 following the attempted elopement. DON noted R2 would not be safe to go out into the community independently and would not be able to make her own decisions safely. The DON confirmed there was no monitoring in place for R2's wandering behaviors. The DON was not able to identify how the interventions added to R2's care plan related to elopement risk were determined to be individualized, comprehensive, or effective in the absence of a comprehensive elopement risk assessment and behavior monitoring. During an interview on 9/26/24 at 4:07 p.m., R2's primary care physician who was also the facility's medical director reported R2 had severe dementia and patterns of wandering in the hallway. The medical director noted R2 had severe cognitive limitations and impaired decision making due to dementia. He noted R2 would not be successful on her own in the community and would not be safe by herself. The medical director stated, "she is an elopement risk" and "definitely needs monitoring" of her wandering behaviors. The medical director expected elopement assessments would have been completed for R2, including an assessment following the elopement	2 830		

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attempt on 9/6/24. The medical director further expected R2 would be "being monitored and I would expect that she would have immediate interventions" in place to reduce the risk of elopement.

An untitled facility policy regarding elopement dated September 2024 included:
"All residents are to be assessed for elopement risk and those found at risk will have a resident care plan that addresses the issue ... 2.) A Resident Elopement Risk Assessment will be performed at the following times: At time of admission, quarterly, annually, significant change in condition or in Resident behavior, after an elopement attempt, after return from a hospital stay of at least 24 hours, verbalizing desire to leave the facility, anytime a staff member feels a need to reassess a Resident. 3.) If found to be at risk, implement Plan of Care ... In the case of an elopement: ... 11.) Update Resident's service plan/plan of care to indicate elopement risk and provide approaches to maintain Resident's safety."

The immediate jeopardy that began on 9/5/24, was removed on 10/3/24, when it was verified the facility implemented the following corrective actions: comprehensively assessed all residents for elopement risk, level of supervision needed, appropriate interventions, efficacy of current interventions, and updated care plans accordingly; reviewed and revised elopement policies and procedures; identified residents at high risk of elopement and ensured resident-specific interventions were implemented; assessed the need for and implemented behavioral monitoring for wandering and elopement risk behaviors; and educated all staff on elopement

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SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could review/revise policies and procedures related to appropriate supervision to paid feeding assistants and appropriate use of paid feeding assistants. The DON or designee could also and ensure appropriate comprehensive assessments and interventions were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk for choking/swallowing issues. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential choking/swallowing issues and oversight of the paid feeding assistants. The DON or designee should also ensure staff perform a comprehensive assessment or root cause analysis as needed to ensure interventions are effective, in place and re-evaluated as often as necessary. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.