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

Electronically Delivered
October 3, 2024

Administrator
Ebenezer Integrated Care & Rehab
45 West 10th Street
Saint Paul, MN 55102

RE: CCN: 245587
Cycle Start Date: July 25, 2024

Dear Administrator:

On October 2, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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Electronically delivered

October 3, 2024

Administrator
Ebenezer Integrated Care & Rehab
45 West 10th Street
Saint Paul, MN 55102

Re: Reinspection Results
Event ID: GYVJ12

Dear Administrator:

On October 2, 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 July 25, 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 delivered
August 14, 2024

Administrator
Ebenezer Integrated Care & Rehab
45 West 10th Street
Saint Paul, MN 55102

RE: CCN: 245587
Cycle Start Date: July 25, 2024

Dear Administrator:

On July 25, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 25, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 25, 2025 (six months after

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

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245587 | A. BUILDING ______ B. WING ______ | C 07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EBENEZER INTEGRATED CARE & REHAB | 45 WEST 10TH STREET SAINT PAUL, MN 55102 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 7/24/24 and 7/25/24, 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.<br><br>The following complaints were reviewed:<br>H55875398C (MN00104754)<br>H55876228C (MN00105020)<br>H55876227C (MN00105124)<br>H55876215C (MN00105191)<br>with deficiencies cited at F689 and F760.<br><br>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.<br><br>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 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent | F 689 | | 9/2/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/23/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| **EBENEZER INTEGRATED CARE & REHAB** | **45 WEST 10TH STREET**<br>**SAINT PAUL, MN 55102** |

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F 689

Continued From page 1

accidents.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide adequate supervision when staff allowed a family member to take a resident into the community where R4 subsequently fell and was hospitalized.

R4's significant change Minimum Data Set (MDS) dated 5/30/24, indicated R4 had impaired cognition with diagnoses including dementia.

R4's care plan dated 7/24/24, indicated was an elopement risk due to cognitive ability, and history of wandering during the night and when out in the community. R4 was also a fall risk due to confusion and deconditioning.

R4's hospital discharge summary dated 4/26/24, included a note by the hospital social worker which indicated there was an open vulnerable adult protection case as of 4/21/24. R4 had been placed in an assisted living and family member (FM)-B removed R4 against medical advice. FM-B also had lost R4 in their apartment building. She was unable to locate R4 and external parties were involved in locating R4. The note further indicated there would likely be concerns from the long-term care facilities about FM-B removing R4 against medical advice. Additionally, the note indicated part of the hospital discharge plan was for the receiving facility to not allow FM-B to bring R4 out of the facility.

R4's Electronic Health Record (EHR) included special instructions: resident is not to go on outings or leave of absence with family, and call

F 689

F000
Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance.

F689
1. Corrective Action: R4's chart has been updated to reflect, more clearly, the contact's inability to remove R4 from the unit without additional supervision. R4 now has a "wander guard" on their person. This wander guard serves as an additional safety measure for the resident and triggers staff in the case that the resident and contact were to attempt to follow another visitor, contractor, etc. off the secured unit. Specific education was provided to the unit staff and charge nurses about R4's primary contact's restrictions.

2. Corrective Action as it applies to other residents: Facility-wide education was provided on EICR's visitation/visitor escort policy. Education was provided to the nursing team regarding the "special

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| F 689 | Continued From page 2<br>security for assistance as needed.<br><br>On 7/24/24, a progress note indicated FM-B asked the nurse if she could take R4 out of the building. The nurse said she could not, and directed FM-B to talk to the nurse manager. At 3:50 p.m. R4 was discovered missing, and FM-B was called. FM-B told staff they were at the train station, and R4 had fainted. Staff went to the train station then called 911. Emergency medical services (EMS) transported R4 to the hospital for possible stroke.<br><br>On 7/25/24 at 2:44 p.m., registered nurse (RN)-B stated there was information placed in R4's EHR on admission to not let him go out with FM-B because there were some problems with FM-B not keeping track of him in the community.<br><br>On 7/25/24 at 3:48 p.m., RN-C stated she had told FM-B she could not take R4 out of the building. RN-D told FM-B she could take R4 out of the building because she was his primary contact. Later, when R4 was discovered missing, RN-B told RN-C FM-B was not allowed to take R4 out of the building. RN-C stated she did not see the information in the EHR about R4 not going out of the building with family.<br><br>On 7/25/24 at 4:57 p.m., nursing assistant (NA)-A stated FM-B had requested a four wheeled walker so she could take R4 into the community. She relayed the request to RN-C and RN-D. The nurses requested NA-A to find out FM-B's name so they could confirm FM-B was allowed to take R4 into the community. Upon confirming FM-B's name, RN-D stated it was ok for FM-B to take R4 into the community. NA-A opened the locked | F 689 | instructions” section of the Chart/Kardex of a resident.<br><br>3. Date of Completion: 9/2/24<br><br>4. Reoccurrence will be prevented by: Any future restrictions will be communicated to the team in the following ways:<br>a. Via secured email to all members of the staff (messaging to come from the Social Service’s Team)<br>b. Via nursing “huddles” which occur M-F for AM and PM shift nurses and NARs (Unit Managers to provide this communication)<br>c. Via EICR’s weekly staff newsletter, located in the badge-accessed employee break room (Administration to include in staff newsletter)<br>d. Via Chart/Kardex under the “special instructions” section (Social Services/Unit Managers to input into PCC)<br><br>5. The Correction will be monitored by: The Social Services Team, Unit Managers and Administrator | |

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| F 689 | Continued From page 3<br>memory care door for FM-B because RN-D confirmed it was ok. NA-A had gone to the train station three blocks away after FM-B informed the facility R4 had fainted. NA-A checked for a pulse and breathing then called 911. NA-A stated R4 was stiff and would not wake up.<br><br>On 7/25/24 at 5:34 p.m., the director of nursing (DON) stated at the beginning of R4's stay, staff were nervous because of what they had been told about FM-B from hospital staff. R4 had a WanderGuard (alarm) placed on admission to prevent FM-B from removing R4 from the unit, but R4 was not exit seeking and FM-B had not visited, so it was removed. R4 continued to remain on the locked memory care unit where a staff badge was required for exit. The DON confirmed staff should not have allowed FM-B to remove R4 from the unit. R4 had been admitted to the hospital on 7/24/24 for suspected seizure.<br><br>A policy on allowing visitors to take residents out of the building was requested but not provided. | F 689 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure residents were free of significant medication errors for 2 of 3 residents (R2, R3) reviewed for medication errors.<br><br>R2's admission Minimum Data Set (MDS) dated 6/20/24 indicated R2 had severely impaired | F 760 | F000<br>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies | 9/26/24 |

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F 760

Continued From page 4

cognition, with diagnoses including dementia and depression.

R2's hospital discharge orders dated 6/14/24 included vortioxetine (an antidepressant medication) 5 milligrams (mg) daily for adjustment disorder with mixed anxiety and depressed mood.

R2's Medication Administration Records (MAR) for June 2024 and July 2024 lack indication vortioxetine was administered. R2 missed 16 doses in June 2024 and 17 doses in July 2024.

R2's Consultant Pharmacist (CP) note dated 7/17/24 indicated the hospital discharge order for vortioxetine could not be located in R2's electronic health record (EHR) Physician Orders list.

A facility report to the State Agency (SA) on 7/18/24 indicated R2 had not received vortioxetine since admission on 6/14/24.

R3's quarterly MDS dated 4/30/24 indicated R3 had moderately impaired cognition, with diagnoses including depression, anxiety, and psychosis.

R3's provider Telephone Order (TO) dated 6/7/24 instructed Abilify 5 (antidepressant) mg PO (by mouth) daily and 2mg PO Q2H (every 2 hours) PRN (as needed) x 14 days for delusion, paranoia, and hallucinations.

R3's handwritten TO dated 7/22/24 instructed Abilify oral tablet give 5mg by mouth daily for paranoia. There are no initials in the column that indicated the order was transcribed into Point Click Care electronic medication administration

F 760

and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility’s allegation of compliance.

F760

1. Corrective Action:
R2- the Vortioxetine was discontinued on 7/18/24 upon the provider's review.
R3- the Abilify was restarted on 7/25/24.

2. Corrective Action as it applies to other residents: A facility wide chart audit was completed to capture any other medications that may have not been transcribed. Policies and procedures for transcription of physician orders were reviewed and remains appropriate. Staff responsible for transcription of physician orders were re-educated on the process of transcribing and verification of physician orders.

3. Date of Completion: 9/26/24.

4. Reoccurrence will be prevented by: All new admissions will be audited for 30 days to ensure all orders are processed accurately, then 1 new admission weekly for 2 months to ensure ongoing compliance. 5 random medication orders will be audited weekly for 1 month, then 5 random medication orders monthly for 2

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| F 760 | Continued From page 5 | F 760 | | |

record (eMAR) or that the order was second checked.

R3's June MAR indicated Abilify 5 mg by mouth one time a day for delusions, paranoia, hallucinations for 14 days. It was administered daily from 6/8/24 through 6/21/24. There were no administrations of Abilify from 6/22/24 through 6/30/24 (8 doses).

R3's July MAR lacked instruction to administer Abilify from 7/1/24 through 7/25/24 (25 doses).

On 6/19/24 R3's psychiatrist note indicated Abilify seemed to have helped with targeting hallucinations as staff reported there have been no notes or concerns regarding psychosis or concerns of bugs crawling all over her.

On 6/26/24 R3's behavior note indicated R3 told the trained medication assistant there were bugs crawling all over her body.

On 7/10/24 R3's nurse practitioner (NP)-A note indicated R3 reported seeing bugs on her body and bed. R3 was anxious about this and wanted medication adjustment as able. NP-A indicated Oxycodone would be restarted because that has been the first medication change which perhaps prompted the hallucinations of bugs. The medication list on NP-A's note did not list Abilify.

On 7/22/24 R3's NP-A note indicated R3 reported worsening hallucinations of seeing bugs all over her body, into her hair and into her eyes. R3's left eye was visibly red suspected to scratching eye. Also, various scratch marks over face, chin and

months. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations.
5. The Correction will be monitored by: Director of Nursing or Designee

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| F 760 | Continued From page 6 | F 760 | | |

chest. R3 was moderately distressed given hallucination complaints. NP-A reached out to R3's psychiatrist with current medication orders. It was discovered R3's scheduled and PRN Abilify had been discontinued instead of just the PRN order. NP-A advised to monitor for worsening symptoms of hallucinations and delusions. NP-A ordered to restart Abilify 5mg daily per psychiatrist recommendations.

On 7/25/24 at 10:52 a.m., family member (FM)-A stated R3 had hallucinations a while ago, but then they went away. The hallucinations were back again. R3 was feeling bugs crawl on her, so she was scratching at her skin. FM-A thought the hallucinations were disturbing to R3.

On 7/24/24 at 3:22 p.m., licensed practical nurse (LPN)-A verified R3 did not have an active order for Abilify.

On 7/25/24 at 12:02 p.m., registered nurse (RN)-A stated she transcribed the order for Abilify on 6/7/24. She thought both the scheduled and PRN dosing were for 14 days. She should have clarified with the provider. There was no procedure for nursing to follow up with a provider when a medication was ordered for a specific time frame. She would assume the provider would be reassessing automatically. The nurse would only follow up if the order specified to follow up with provider.

On 7/25/24 at 4:42 p.m., psychiatrist (MD-A) stated R3 was prescribed Abilify for tactile hallucinations. She was contacted by NP-A regarding R3's increased hallucinations on

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| F 760 | Continued From page 7<br>7/22/24. She reviewed R3's medication orders because she wanted to increase R3's Abilify dose. The Abilify was not on R3's current medication list. She communicated to NP-A to reorder Abilify. She confirmed she had not given an order to discontinue the Abilify, and the scheduled dose should not have been transcribed for 14 days. Missing doses of Abilify may have contributed to R3's increased hallucinations. She expected orders to start the day after she wrote the order to give the facility time to obtain the medication from the pharmacy. Abilify should have been administered starting 7/23/24.<br><br>On 7/25/2024 at 5:34 p.m. director of nursing (DON) stated when a new admission arrived at the facility, provider orders were first entered by the health unit coordinator or by a nurse. All orders must be second checked by a nurse. All pages of a resident's discharge order summary should be checked for provider orders. R2's discharge order summary had been double checked, but the order for vortioxetine was on the top of the last page of orders and had been missed by both nurses. The missing order was discovered by the consulting pharmacist. A facility wide chart audit was not completed to assess if there were any other medications that had not been transcribed. R3's Abilify order should have been clarified by the provider before entering the 14-day time frame. R3's provider order dated 7/22/24 for Abilify was not transcribed according to facility policy. There should have been initials in the column that indicated the order was transcribed into Point Click Care electronic medication administration record (eMAR) or that the order was verified. Handwritten provider orders should be placed in | F 760 | | |

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| | 245587 | A. BUILDING ______<br>B. WING ______ | C<br>07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **EBENEZER INTEGRATED CARE & REHAB** | **45 WEST 10TH STREET**<br>**SAINT PAUL, MN 55102** |

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| F 760 | Continued From page 8<br>appropriate bins for order to be entered, second checked then uploaded. It appeared the order was placed into the "to be uploaded" bin before the order was transcribed. Abilify had been ordered for R3 to treat hallucinations.<br><br>The Transcription of Physician's Orders policy dated 8/23 directed to ensure accurate transcription of physician orders the order is documented by physician or nurse practitioner. The HUC or nurse transcribes the order into Point Click Care and signs off. The order is faxed to pharmacy. The order is double checked by a nurse and signed off as checked. HUC uploads any paper copies of orders into point Click Care. | F 760 | | |

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

Electronically delivered
August 14, 2024

Administrator
Ebenezer Integrated Care & Rehab
45 West 10th Street
Saint Paul, MN 55102

Re: State Nursing Home Licensing Orders
Event ID: GYVJ11

Dear Administrator:

The above facility was surveyed on July 24, 2024 through July 25, 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 7/24/24 and 7/25/24, 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 | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.<br><br>The following complaints were reviewed:<br>H55875398C (MN00104754)<br>H55876228C (MN00105020)<br>H55876227C (MN00105124)<br>H55876215C (MN00105191)<br>with a licensing order issued at 4658.0520 Subp. 1 and 4658.1320.<br>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.<br><br>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 | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>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 state form.<br><br>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 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and 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.<br><br>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision when staff allowed a family member to take a resident | 2 830 | 0830<br><br>1. Corrected Action: R4s chart has been | 9/2/24 |

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| 2 830 | | 2 830 | | |

Continued From page 3

into the community where R4 subsequently fell and was hospitalized.

R4's significant change Minimum Data Set (MDS) dated 5/30/24, indicated R4 had impaired cognition with diagnoses including dementia.

R4's care plan dated 7/24/24, indicated was an elopement risk due to cognitive ability, and history of wandering during the night and when out in the community. R4 was also a fall risk due to confusion and deconditioning.

R4's hospital discharge summary dated 4/26/24, included a note by the hospital social worker which indicated there was an open vulnerable adult protection case as of 4/21/24. R4 had been placed in an assisted living and family member (FM)-B removed R4 against medical advice. FM-B also had lost R4 in their apartment building. She was unable to locate R4 and external parties were involved in locating R4. The note further indicated there would likely be concerns from the long-term care facilities about FM-B removing R4 against medical advice. Additionally, the note indicated part of the hospital discharge plan was for the receiving facility to not allow FM-B to bring R4 out of the facility.

R4's Electronic Health Record (EHR) included special instructions: resident is not to go on outings or leave of absence with family, and call security for assistance as needed.

On 7/24/24, a progress note indicated FM-B asked the nurse if she could take R4 out of the building. The nurse said she could not, and directed FM-B to talk to the nurse manager. At 3:50 p.m. R4 was

updated to reflect, more clearly, the contact□s inability to remove R4 from the unit without additional supervision. R4 now has a wander guard on their person. This wander guard serves as an additional safety measure for the resident and triggers staff in the case that the resident and contact were to attempt to follow another visitor, contractor, etc. off the secured unit. Specific education was provided to the unit staff and charge nurses about R4□s primary contact□s restrictions.

2. Corrective Actions as it applies to other residents: Facility-wide education was provided on EICR□s visitation/visitor escort policy. Education was provided to the nursing team regarding the special instructions section of the Chart/Kardex of a resident.

3. Date of Completion: 9/2/24

4. Reoccurrence will be prevented by: Any future restrictions will be communicated to the team in the following ways:
a. Via secured email to all members of the staff (messaging to come from the Social Service□s Team)
b. Via nursing huddles which occur M-F for AM and PM shift nurses and NARs (Unit Managers to provide this communication)
c. Via EICR□s weekly staff newsletter, located in the badge-accessed employee break room (Administration to include in staff newsletter)
d. Via Chart/Kardex under the special instructions section (Social Services/Unit

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| 2 830 | Continued From page 4<br><br>discovered missing, and FM-B was called. FM-B told staff they were at the train station, and R4 had fainted. Staff went to the train station then called 911. Emergency medical services (EMS) transported R4 to the hospital for possible stroke.<br><br>On 7/25/24 at 2:44 p.m., registered nurse (RN)-B stated there was information placed in R4's EHR on admission to not let him go out with FM-B because there were some problems with FM-B not keeping track of him in the community.<br><br>On 7/25/24 at 3:48 p.m., RN-C stated she had told FM-B she could not take R4 out of the building. RN-D told FM-B she could take R4 out of the building because she was his primary contact. Later, when R4 was discovered missing, RN-B told RN-C FM-B was not allowed to take R4 out of the building. RN-C stated she did not see the information in the EHR about R4 not going out of the building with family.<br><br>On 7/25/24 at 4:57 p.m., nursing assistant (NA)-A stated FM-B had requested a four wheeled walker so she could take R4 into the community. She relayed the request to RN-C and RN-D. The nurses requested NA-A to find out FM-B's name so they could confirm FM-B was allowed to take R4 into the community. Upon confirming FM-B's name, RN-D stated it was ok for FM-B to take R4 into the community. NA-A opened the locked memory care door for FM-B because RN-D confirmed it was ok. NA-A had gone to the train station three blocks away after FM-B informed the facility R4 had fainted. NA-A checked for a pulse and breathing then called 911. NA-A stated R4 was stiff and would not wake up. | 2 830 | Managers to input into PCC)<br><br>Administrator will also complete random audits to ensure staff are aware of visitor restrictions. Audits will entail approaching staff members and asking how they know if someone has visitor restrictions and who on their unit currently has restrictions.<br><br>5. The Correction will be monitored by: The Social Services Team, Unit Managers and Administrator | |

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| 2 830 | Continued From page 5<br>On 7/25/24 at 5:34 p.m., the director of nursing (DON) stated at the beginning of R4's stay, staff were nervous because of what they had been told about FM-B from hospital staff. R4 had a WanderGuard (alarm) placed on admission to prevent FM-B from removing R4 from the unit, but R4 was not exit seeking and FM-B had not visited, so it was removed. R4 continued to remain on the locked memory care unit where a staff badge was required for exit. The DON confirmed staff should not have allowed FM-B to remove R4 from the unit. R4 had been admitted to the hospital on 7/24/24 for suspected seizure.<br><br>A policy on allowing visitors to take residents out of the building was requested but not provided.<br><br>Suggested Method of Correction:<br>The director of nursing (DON) or designee could review/revise policies and procedures on supervision while taking residents out of the building. The DON or designee could educate all staff on these policies and procedures. The DON or designee could audit to ensure all residents have proper supervision when out of the building, and report these findings to their QAPI committee.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty one (21) days | 2 830 | | |
| 21545 | MN Rule 4658.1320 A.B.C Medication Errors<br><br>A nursing home must ensure that:<br>A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State | 21545 | | 9/26/24 |

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| 21545 | Continued From page 6 | 21545 | | |

Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:
(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or
(2) the administration of expired medications.
B. It is free of any significant medication error. A significant medication error is:
(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or
(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.
C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

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| 21545 | Continued From page 7<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure residents were free of significant medication errors for 2 of 3 residents (R2, R3) reviewed for medication errors.<br><br>R2's admission Minimum Data Set (MDS) dated 6/20/24 indicated R2 had severely impaired cognition, with diagnoses including dementia and depression.<br><br>R2's hospital discharge orders dated 6/14/24 included vortioxetine (an antidepressant medication) 5 milligrams (mg) daily for adjustment disorder with mixed anxiety and depressed mood.<br><br>R2's Medication Administration Records (MAR) for June 2024 and July 2024 lack indication vortioxetine was administered. R2 missed 16 doses in June 2024 and 17 doses in July 2024.<br><br>R2's Consultant Pharmacist (CP) note dated 7/17/24 indicated the hospital discharge order for vortioxetine could not be located in R2's electronic health record (EHR) Physician Orders list.<br><br>A facility report to the State Agency (SA) on 7/18/24 indicated R2 had not received vortioxetine since admission on 6/14/24.<br><br>R3's quarterly MDS dated 4/30/24 indicated R3 had moderately impaired cognition, with diagnoses including depression, anxiety, and psychosis.<br><br>R3's provider Telephone Order (TO) dated 6/7/24 instructed Abilify 5 (antidepressant) mg PO (by | 21545 | 21545<br><br>1. Corrected Action:<br>R2- the Vortioxetine was discontinued on 7/18/24 upon the provider's review.<br><br>R3- the Abilify was restarted on 7/25/24.<br><br>2. Corrective Action as it applies to other residents: A facility wide chart audit was completed to capture any other medications that may have not been transcribed. Policies and procedures for transcription of physician orders were reviewed and remains appropriate. Staff responsible for transcription of physician orders were re-educated on the process of transcribing and verification of physician orders.<br><br>3. Date Corrected By: 9/26/24.<br><br>4. Reoccurrence will be prevented by: All new admissions will be audited for 30 days to ensure all orders are processed accurately, then 1 new admission weekly for 2 months to ensure ongoing compliance. 5 random medication orders will be audited weekly for 1 month, then 5 random medication orders monthly for 2 months. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations.<br><br>5. The Correction will be monitored by: | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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mouth) daily and 2mg PO Q2H (every 2 hours) PRN (as needed) x 14 days for delusion, paranoia, and hallucinations.

R3's handwritten TO dated 7/22/24 instructed Abilify oral tablet give 5mg by mouth daily for paranoia. There are no initials in the column that indicated the order was transcribed into Point Click Care electronic medication administration record (eMAR) or that the order was second checked.

R3's June MAR indicated Abilify 5 mg by mouth one time a day for delusions, paranoia, hallucinations for 14 days. It was administered daily from 6/8/24 through 6/21/24. There were no administrations of Abilify from 6/22/24 through 6/30/24 (8 doses).

R3's July MAR lacked instruction to administer Abilify from 7/1/24 through 7/25/24 (25 doses).

On 6/19/24 R3's psychiatrist note indicated Abilify seemed to have helped with targeting hallucinations as staff reported there have been no notes or concerns regarding psychosis or concerns of bugs crawling all over her.

On 6/26/24 R3's behavior note indicated R3 told the trained medication assistant there were bugs crawling all over her body.

On 7/10/24 R3's nurse practitioner (NP)-A note indicated R3 reported seeing bugs on her body and bed. R3 was anxious about this and wanted medication adjustment as able. NP-A indicated Oxycodone would be restarted because that has been the first medication change which perhaps

Director of Nursing or Designee

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prompted the hallucinations of bugs. The medication list on NP-A's note did not list Abilify.

On 7/22/24 R3's NP-A note indicated R3 reported worsening hallucinations of seeing bugs all over her body, into her hair and into her eyes. R3's left eye was visibly red suspected to scratching eye. Also, various scratch marks over face, chin and chest. R3 was moderately distressed given hallucination complaints. NP-A reached out to R3's psychiatrist with current medication orders. It was discovered R3's scheduled and PRN Abilify had been discontinued instead of just the PRN order. NP-A advised to monitor for worsening symptoms of hallucinations and delusions. NP-A ordered to restart Abilify 5mg daily per psychiatrist recommendations.

On 7/25/24 at 10:52 a.m., family member (FM)-A stated R3 had hallucinations a while ago, but then they went away. The hallucinations were back again. R3 was feeling bugs crawl on her, so she was scratching at her skin. FM-A thought the hallucinations were disturbing to R3.

On 7/24/24 at 3:22 p.m., licensed practical nurse (LPN)-A verified R3 did not have an active order for Abilify.

On 7/25/24 at 12:02 p.m., registered nurse (RN)-A stated she transcribed the order for Abilify on 6/7/24. She thought both the scheduled and PRN dosing were for 14 days. She should have clarified with the provider. There was no procedure for nursing to follow up with a provider when a medication was ordered for a specific time frame. She would assume the provider would be reassessing automatically. The nurse would only

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follow up if the order specified to follow up with provider.

On 7/25/24 at 4:42 p.m., psychiatrist (MD-A) stated R3 was prescribed Abilify for tactile hallucinations. She was contacted by NP-A regarding R3's increased hallucinations on 7/22/24. She reviewed R3's medication orders because she wanted to increase R3's Abilify dose. The Abilify was not on R3's current medication list. She communicated to NP-A to reorder Abilify. She confirmed she had not given an order to discontinue the Abilify, and the scheduled dose should not have been transcribed for 14 days. Missing doses of Abilify may have contributed to R3's increased hallucinations. She expected orders to start the day after she wrote the order to give the facility time to obtain the medication from the pharmacy. Abilify should have been administered starting 7/23/24.

On 7/25/2024 at 5:34 p.m. director of nursing (DON) stated when a new admission arrived at the facility, provider orders were first entered by the health unit coordinator or by a nurse. All orders must be second checked by a nurse. All pages of a resident's discharge order summary should be checked for provider orders. R2's discharge order summary had been double checked, but the order for vortioxetine was on the top of the last page of orders and had been missed by both nurses. The missing order was discovered by the consulting pharmacist. A facility wide chart audit was not completed to assess if there were any other medications that had not been transcribed. R3's Abilify order should have been clarified by the provider before entering the 14-day time frame. R3's provider order dated 7/22/24 for Abilify was

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not transcribed according to facility policy. There should have been initials in the column that indicated the order was transcribed into Point Click Care electronic medication administration record (eMAR) or that the order was verified. Handwritten provider orders should be placed in appropriate bins for order to be entered, second checked then uploaded. It appeared the order was placed into the "to be uploaded" bin before the order was transcribed. Abilify had been ordered for R3 to treat hallucinations.

The Transcription of Physician's Orders policy dated 8/23 directed to ensure accurate transcription of physician orders the order is documented by physician or nurse practitioner. The HUC or nurse transcribes the order into Point Click Care and signs off. The order is faxed to pharmacy. The order is double checked by a nurse and signed off as checked. HUC uploads any paper copies of orders into point Click Care.

Suggested Method of Correction:
The director of nursing (DON) or designee could review/revise policies and procedures on transcribing provider orders. The DON or designee could educate all staff on these policies and procedures. The DON or designee could audit to ensure all staff members are appropriately transcribing provider orders and report these findings to their QAPI committee.

TIME PERIOD FOR CORRECTION:
Twenty one (21) days