STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48037 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. The immediate jeopardy began on [DATE] 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 [DATE]. The immediate jeopardy was identified on [DATE] and the chief executive officer and director of nursing (DON) were notified of the immediate jeopardy on [DATE] at 6:18 p.m. The immediate jeopardy was removed on [DATE] 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. Findings include R1's significant change Minimum Data Set (MDS) dated [DATE], 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 [DATE], 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 [DATE], contained a mental status section. The wanders box was selected with a checkmark with no other information identified. R1's quarterly MDS dated [DATE], indicated R1 did not have wondering behaviors even though the fall risk assessment dated [DATE] 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. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's record reviewed between [DATE] and [DATE], 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 [DATE]. R1's progress note dated [DATE], 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 [DATE], 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] at 3:53 p.m., indicated resident wandered down to main floor and was going outdoors. R1's Fall Risk assessment dated [DATE], identified R1 wandered, but lacked further information about his wandering behaviors or elopement risk. During an interview on [DATE] at 10:20 a.m., 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 [DATE] 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 [DATE], 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Even though R1's MDS assessment dated [DATE] identified R1 had wandering behaviors, R1's record did not include a comprehensive 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 [DATE] that identified R1 was an elopement risk/wanderer with a history of attempts to leave the facility unattended and impaired safety awareness. Interventions dated [DATE] 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 [DATE], 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 ([DATE]). 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 [DATE] and not evident R1's care plan was revised. R1's progress note dated [DATE] 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 family, but it did not work. R1's progress note dated [DATE] 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 [DATE] 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's first recorded Elopement Risk Evaluation dated [DATE] 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 readmitted 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 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 [DATE] and [DATE]. 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 [DATE] to [DATE] when R1 repeatedly demonstrated wandering behaviors while improperly dressed, attempted to elope once, and successfully eloped once. A facility Elopement Incident Report dated [DATE], noted R1's elopement on [DATE] 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 [DATE] 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 [DATE] 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 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 [DATE], [R1] is able to walk independent[[NAME]] 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 [DATE]: - 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 [DATE] that included: - Notify nurse if resident starts exhibiting exit seeking behaviors (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Redirect resident if he is wandering. Review of R1's 30-minute safety checks documented on paper between [DATE] through [DATE] 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 [DATE]. During a return phone call interview on [DATE] at 3:09 p.m., security officer (SO)-A stated he worked on [DATE] and saw R1 go outside for 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 [DATE] at 11:33 a.m., contracted registered nurse (CRN)-A stated she was working on [DATE] 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 [NAME] 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 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 [DATE], it should have been done prior, I was shocked when I didn't find more elopement assessments on him During an interview on [DATE] at 3:43 p.m., nursing assistant (NA)-A reported she was the nursing assistant for R1 on [DATE] 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 [DATE] but was not aware of additional interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] 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 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 ([DATE]) 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 [DATE] 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 [DATE] 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 [DATE]. However, LPN-A stated he worked on [DATE] 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 [DATE], 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 [DATE], 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 [DATE] 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] 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 [DATE] at 1:53 p.m. DON and registered nurse (RN)-A, the DON confirmed the assessment completed on [DATE] 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 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 [DATE] his care plan was not updated until [DATE]. RN-A noted R1 later eloped on [DATE] and his care plan was not updated until [DATE] 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 [DATE] 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 [DATE] at 3:49 p.m., the facility's medical director stated he was aware of R1's elopement on [DATE]. 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. [NAME] and proximity to busy streets. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2 R2's MDS dated [DATE], 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 [DATE] 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 elopement. R2's progress note dated [DATE], identified R2 came out of her room agitated and worried while calling out loudly several times, where is [NAME]? The writer discovered [NAME] 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 [DATE], identified R2 was disoriented, but the pre-populated wandering and intermittent confusion behaviors were not selected. R2's progress note dated [DATE] 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 [DATE], 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 seeking. Further, R2's record did not identify implementation of immediate interventions after R2's exit seeking behaviors on [DATE] and the care plan was not revised until [DATE], six (6) days after the incident. R2's care plan included a focus on behavior initiated on [DATE] 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 [DATE] 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 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 [DATE] 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 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 [DATE] 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 [DATE] 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 [DATE] at 8:44 a.m., family member (FM)-A stated she was aware R2 had been looking for her dog on [DATE] 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 [DATE] 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 room to the dining room and reported an incident where R2 was looking for her dog on [DATE]. RN-A stated R2 had gone down to the first floor on [DATE] 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 [DATE]. 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 [DATE] 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] 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 attempt on [DATE]. 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 [DATE] 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 [DATE], was removed on [DATE], 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 ris[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48037 Based on interview and document review, the facility failed to complete annual performance evaluations for 4 of 5 nursing assistants (NA-D, NA-E, NA-F and NA-G) who had been employed by the facility for over one year. Findings include: NA-D personnel record identified a hire date of 4/9/2007, with the last performance evaluation completed on 4/29/2020 and additional one completed in 2016. NA-E personnel record identified a hire date of 3/3/2005, with the last performance evaluation completed on 5/19/2021. NA-F- personnel record identified a hire date of 8/19/2020, with no job performance review. NA-G - personnel record identified a hire date of 04/29/201,5 with the last performance evaluation completed on 5/8/2020. During interview on 10/2/24 at 4:24 p.m., NA-G reported to have been working for the facility for 13 or [AGE] years. NA-G was unaware of when the last performance review completed. NA-G thought it was completed in the last year, however reported the facility has been very busy in the last three years. During a a return phone interview from 10/2/24 at 4:19 p.m., NA-F reported not having a performance review in approximately three years, sometime last done around 2020, NA-F was aware performance reviews were to be completed yearly, however didn't say anything to anyone and was unaware why they had not been completed. During interview on 10/2/24 at 4:27 p.m., NA-E reported the last performance review completed was around 2020 it had been a couple years since last one was completed. During interview on 10/2/24 at 2:35 p.m., human resources manager (HR)-A and director of nursing (DON). HR-A reported the employee files did not include annual performance reviews. NA-D's performance was last done on 4/29/2020, NA-E was last done on 5/19/2021, no record or evidence NA-F had completed a performance review and NA-G's was last completed on 5/8/2020. DON reported the facility did not have a staff development person and the job would be up to staff development to manage those tasks. The process should be for staff to have one completed yearly and it would be submitted to Human Resources and kept in employee files. Policies reguarding performance reviews requested, not received. 49338

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 48037 49338 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 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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 [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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48037 49338 Based on interview and document review, the facility failed to ensure the Facility Assessment (FA) was complete and included an evaluation of the resident population and its needs using evidence-based data driven methods, the competencies and skill sets for all personnel necessary to provide that care, information on staffing levels needed based on the resident population, a plan for maximizing recruitment and retention of direct care staff, and all contracted services required to meet resident needs. The facility further failed to ensure the FA was conducted with input from all necessary individuals. This had the potential to affect all 36 residents residing in the facility. Findings include Facility assessment dated [DATE]th, 2024 through September 30th, 2024 (after survey entered), identified Administrator-A as CEO/Administrator and governing board. Facility assessment identified director of nursing (DON) to be involved in completing the facility assessment. Dates of assessments with review by QAPI/QAA dated 7/19/2024. The review of the assessment identified the following: 1) Facility assessment identified resident census and population by categorizing diseases and conditions, however lacked evaluation of the resident population and its needs based on acuity using evidence-based data driven methods. Title of acuity over the past year was blank. 2) Facility assessment reviewed for information on staffing levels needed based on the resident population. FA's page 9 identified a staffing plan based on full time equivalent (FTE's), however did not identify staffing levels required for specific shifts such as day, evening, and night and how it would be adjusted based on changes to resident population. 3) Facility assessment did not include competencies and skill sets for all personnel necessary to provide appropriate care. The facility assessment only included: the facility was a roman catholic organization. Various priests and deacons of the Archdiocese of Saint [NAME]/ Minneapolis to see the spiritual needs of our elderly. For those residents of other Christian denomination, pastors of their church come to the facility to offer spiritual help according to the needs of the elderly. 4) Facility assessment did not identify job descriptions for contracted registered nurses, unit supervisor or training. Additionally, it lacked job description/training/competency for volunteers mentioned in the FA related to resident care. Page 10 stated each job description identifies the required education and credentials, however lacks further detail on what is required. Page 11 directs you to refer to training and orientation plan. Training and orientation plan requested and not received. Job descriptions/policies for volunteers and unit supervisors, training and competency requested and not received. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) Facility assessment reviewed for plan for maximizing recruitment and retention of direct care staff. Page 12 titled Describe the plan to recruit and retain employees who are knowledgeable of appropriate medical practices depending on the care of the residents. Lacked information on recruitment strategies or retention plan. 6) Facility assessment reviewed for plan for all contracted services required to meet resident's needs did not identify specific contracted services such as hospice, therapy, podiatry, audiology, vision or nutrition used in the facility. During interview on 10/2/24 at 8:10 a.m., regional consultant (RC) was unaware of a facility policy for volunteers. During interview on 10/2/24 at 9:48 a.m., Administrator-(B) identified to be the new acting Administrator as of 10/2/24 and reported being aware of the updated guidance and regulations for expectations of FA's. Administrator-B referred to page three and identified the FA described the resident condition and diagnosis, however lacked information regarding acuity. The information about specific staffing needs for shifts and units was not in the facility assessment. Administrator-(B) was unable to identify how the facility used the FA to inform staffing decisions and consider specific staffing needs for each resident until in the facility for each shift. Administrator-(B) reported the FA did not identify a recruit or retention plan. During interview on 10/2/24 at 9:00 a.m., DON reported she would not be the appropriate person to speak to regarding the FA. DON had never seen the FA and was uninvolved in its creation. During interview on 10/3/24 at 11:42 a.m., stand in chief executive officer (SCEO) and contracted registered nurse, CRN-A identified the facility assessment was updated over the weekend (September 28th to 30th). SCEO and CRN-A reported awareness of the updates the facility assessment required, however CNR-A did not feel responsible for mandatory regulatory updates and felt it was an administration duty. SCEO indicated she updated the assessment to include projects and quality meeting dates, but was not able to update any other part of the assessment because she was not in charge of it. CRN-A did not recall reviewing facility assessment at the quality meeting in July because she thought administrator-A had competed the review. During interview on 10/3/24 at 12:08 p.m., DON and SCEO reported the facility assessment was not up to date. SECO reported the facility should have an up-to-date facility assessment which reflected the facility needs. DON reported the facility should have policies in place for education, training, and competency of nursing staff. DON expressed it was very important for the facility to have knowledgeable staff for the work they are responsible for. FA policy requested and not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 48037 49338 Based on interview and document review, the facility failed to have a written transfer agreement with a hospital approved for participation under Medicare or Medicaid programs which reasonably ensured residents would be transferred to the hospital and ensured timely admission. This had the potential to affect all 36 residents in the facility who could require hospitalization on an emergency basis. Findings include: During a review of the facility's policies and procedures, a written transfer agreement was requested to demonstrate the facility had a transfer agreement in place with a Medicare and Medicaid participating hospital. During an interview on 10/1/24 at 2:45 p.m., the director of nursing (DON) stated she was unable to find a written transfer agreement with a hospital. She stated to her knowledge the facility did not have a transfer agreement and had not made a good faith effort to enter into an agreement with a hospital which was refused. Facility policy titled Hospital Transfers dated 11/10, did not address a transfer agreement with a hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48037 49338 Based on document review and interview the facility failed to submit complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (Q3), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This had the potential to affect all 36 residents residing in the facility. Findings include Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705D dated 5/1/24 through 6/30/24 (Q3), identified no triggered metrics for staffing. During interview on 10/2/24 at 2:45 p.m., Providence payroll administrator (PA), reported her job role was to submit and complete the payroll-based journal regionally for Little Sisters of the Poor. PA explained the process was for the contracted services for the sisters who were considered contracted staff to submit reportable hours worked with a sisters contracted service time sheet via email. PA would use those emails to submit time into PBJ. PA was unaware of any process in place for how time was divided between spiritual hours which could not be constituted as direct care and direct care hours. During interview on 10/3/24 at 11:32 a.m., contracted nursing assistant CNA-A was the unit supervisor for the facilities fourth floor. CNA-A reported job duties included assisting getting residents up for the day, transferring residents, assisting in the dining room with tasks such as passing juice and cookies for meals. CNA-A reported residents on the fourth floor were pretty independent and did not require assistance for feeding but she would bring food to the table. CNA-A worked 7 days a week Monday through Sunday and took a vow of hospitality, which was different than an employee. CNA-A explained shifts she would assist with were not in a continuous chunk of time, but an as needed basis. CNA-A explained she assisted when staff called in during the middle of the night and on different floors; her job duties were to fill in and assist in the care of the residents. CNA-A reported the care was broken up and every day was different as far as quantity of hours providing direct job duties. CNA-A reported most of the residents could care for themselves and the care which was provided was spiritual care and talking with residents. The majority of the time and care provided to residents was to help assist residents with internal conflict CNA-A did not have any way of tracking specific hours or documented times of when she provided direct care and when spiritual care was provided. CNA-A's employee file was reviewed; the file did not include a job description that would define contracted staff roles or expectations. Review of the form titled sisters contracted service time sheet for PBJ direct care hours contracted identified contracted nursing assistant CNA(A) under job title of unit supervisor. The form identified CNA-A worked the following hours during quarter 3 (Q3). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-5/12-5/25 - 76 hours for day shift 7:00 a.m.-3:00 p.m. -5/26-6/8 -76 hours for day shift 7:00 a.m.-3:00 p.m. -6/9-6/22 -76 hours for day shift 7:00 a.m.-3:00 p.m. -6/23-6/30-40 hours for day shift 7:00 a.m.-3:00 p.m. For a total of 268 hours Review of the facility's PB&J for Q3 submitted to CMS identified the hours the facility reported for contracted and facility staff for CNA-A was 492 hours which conflicted with the 268 hours identified on the facility form. In review of Q3 staffing schedules, CNA-A was not identified, actual direct care hours CNA-A performed could not be ascertained and there was no accounting of the difference of hours between the facility's contracted time sheet and the staff hours recorded and submitted to CMS. During interview on 10/1/24 at 4:04 p.m., certified registered nurse (CRN)-A, reported to work on the floor as needed to provide direct cares for staff call-ins or when the facility needs more assistance with residents. CRN-A did not identify as an employee however, identified as an unpaid volunteer with religious significance. CRN-A was a licensed registered nurse which qualified her to work on the floor as such. CRN-A reported to be active in the facility 24/7 and was weaved into the fabric of the day as needed. CRN-A would assist with all cares including medication pass, transfers and wound care. Additionally, would provide spiritual time as needed throughout the day. CRN-A worked as needed at night for sick call if an employee of the facility was not able to make it. CRN-A was aware of reportable hours for PBJ but was unaware of the details. CRN-A reported there was no way to track the hours and worked in chunks throughout the day as needed. CRN-A was unaware of a process that identified spiritual hours from direct care hours. CRN-A's employee file was reviewed; the file did not include a job description that would define contracted staff roles or expectations. Review of the form titled sisters contracted service time sheet for PBJ direct care hours contracted identified CRN-A under job title of unit supervisor, registered nurse. The form identified CRN-A worked the following hours during Q3. -5/12 -5/25 100 hours for day shift 7:00 a.m.-3:00 p.m. -5/26-6/8 24 hours for day shift 7:00 a.m.-3:00 p.m. -6/9-6/22 72 hours for day shift 7:00 a.m.-3:00 p.m. -6/23-6/30 48 hours for day shift 7:00 a.m.-3:00 p.m. For a total of 244 hours for Q3. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's PB&J for Q3 submitted to Centers for Medicaid/Medicare Services (CMS) identified the hours the facility reported for contracted and facility staff for CRN-A was 328 hours which conflicted with the 244 hours identified on the facility form. In review of Q3 staffing schedules, CRN-A was not identified, actual direct care hours CRN-A performed could not be ascertained and there was no accounting of the difference of hours between the facility's contracted time sheet and the staff hours recorded and submitted to CMS. During interview on 10/3/24 at 11:45 a.m., CRN-B reported to assist with bringing residents to church services, going out to different marketplaces asking for community members financial donations, assisting residents with nail care and light activities of daily living (ADL's). CRN-B was aware of providing time to payroll administrator (PA) for accounting purposes. CRN-B did not always complete 8 hour shifts of direct care services as the care was on an as needed bases. CRN-B was unaware of any tracking the facility did for spiritual care versus direct patient care. CRN-B's employee file was reviewed; the file did not include a job description that would define contracted staff roles or expectations. Review of the form titled sisters contracted service time sheet for PBJ direct care hours contracted identified CRN-B under job title of unit supervisor, registered nurse. The form identified CRN-B worked the following hours during Q3. -5/12-5/25 72 hours for day shift 7:00 a.m.-3:00 p.m. -5/26-6/8 72 hours for day shift 7:00 a.m.-3:00 p.m. -6/9-6/22 -80 hours for day shift 7:00 a.m.-3:00 p.m. For a total of 224 for Q3. Review of the facility's PB&J for Q3 submitted to Centers for Medicaid/Medicare Services (CMS) identified the hours the facility reported for contracted and facility staff for CRN-B was 472 hours which conflicted with the 224 hours identified on the facility form. In review of Q3 staffing schedules, CRN-B was not identified, actual direct care hours CRN-B performed could not be ascertained and there was no accounting of the difference of hours between the facility's contracted time sheet and the staff hours recorded and submitted to CMS. During interview on 10/2/24 at 3:03 p.m., human resource manager (HR)-A reported the facility did not have a job description of the unit supervisors nor any contract information for CRN-A, CRN-B or CNA-A on role or contracted services they were able to provide. Request of unit supervisor job description requested and not received. The facility undated policy titled Payroll Based Journal, identified PBJ reporting was to be based on the primary role and/ official job title.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48037 49338 Based on interview and document review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. This had the potential to affect all 36 residents residing at the facility who received care from facility staff, contracted staff, and volunteers. Findings include: SEE F730: Based on interview and document review, the facility failed to complete annual performance evaluations for 4 of 5 nursing assistants (NA-D, NA-E, NA-F and NA-G) who had been employed by the facility for over one year. SEE F947: 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. The Facility Assessment with dates of assessment 1/29/24 to 2/1/24, included Our training program is reviewed and revised as necessary but especially at the time of the Facility Assessment and Refer to Training and Orientation Plan. The Facility Assessment did not identify specific training nor competencies based on the resident population. The facility's training program that was identified in the facility assessment was requested and not received. The facility's Training and Orientation Plan was requested but not received. Policy and procedure regarding training requirements was requested but not received. During an interview on 10/1/24 at 2:50 p.m., the director of nursing (DON) stated she has had concerns about staff education. She noted the facility needed policies to be taken care of and the executive director might be the person to look at policies and identify who is responsible, people needed to be assigned to those duties, and things had been left hanging. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/2/24 at 9:58 a.m., the administrator-B stated he had reviewed the facility assessment and confirmed it addressed the facility's training program. Administrator-B stated he interpreted the facility assessment as directing that staff education is different for every discipline based on their direct care levels, did not see anything identified about education and training for volunteers specifically, and noted the assessment indicated contracted staff would be given a brief orientation and review of the facility prior to coming on to the premise. He was not able to locate further information about competency, training, or education needed for contracted staff. Administrator-B stated the facility assessment referenced a Training and Orientation Plan which should have further details about specific training. During an interview on 10/2/24 at 11:59 a.m. with director of nursing (DON) and human resources manager (HR)-A, DON stated the facility did not have a staff development person to identify and track all the education required for the staff. DON noted nursing staff have competencies completed upon hire at orientation and, after that, based on changes in policies, performance, and new things that happen she had some training's she completed with staff in meetings and on-the-floor training. The DON stated, I do not have an ongoing training plan for nurses after orientation and the competency checklist, and I do not have a standardized plan of training. DON confirmed she did not have one, human resources did not have one, and they did not currently have an employee in the staff development role. The DON confirmed she did not have a facility Training and Orientation Plan as referenced in the facility assessment and furthermore was unfamiliar with the contents of the facility assessment. DON identified a lack of a systemic or structural way of confirming that staff had completed needed education and training's. The DON was unable to identify the amount and types of training necessary for nursing staff or how they were determined and noted that would be in the role of staff development to do those things. HR-A stated, it hasn't been done because there is no process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48037 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 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 [DATE]th 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 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. 49338